Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC)

Location: Hospital Boardroom, Lower Ground Floor, Lift Bank C
Chair: Sir Tom Hughes-Hallett
Date: Thursday, 29 January 2015 Time: 4.00pm

Agenda

Ref	Item	Lead	Time
1	**GENERAL BUSINESS**		**4.00**
1.1	Welcome and Apologies for Absence	TH-H	
1.2	Chairman's Introduction	TH-H	
1.3	Declaration of Interests	TH-H	
1.4	Draft Minutes of the Meeting of the Board of Directors held on 30 October 2014	TH-H	
1.5	Matters arising	TH-H	
1.6	Patient Experience (oral)	VS	
1.7	Chairman's Report (oral)	TH-H	
1.8	Interim Chief Executive's Report	EM	
1.9	Council of Governors Report including Membership Report and Quality Awards	TH-H	
2	**QUALITY**		
2.1	Health and Safety Policy 2014/15	VS	
3	**PERFORMANCE**		
3.1	Finance Report – December 2014	LB/RP	
3.2	Performance and Quality Report – December 2014	RH	
3.2.1	Staff Recruitment and Retention	SY	
3.3	Monitor In-Year Reporting & Monitoring Report Q3	LB	
4	**GOVERNANCE**		
4.1	Register of Interests Annual Review	SY	
4.2	Safeguarding Children Declaration 2015	VS	
5	**STRATEGY**		
5.1	West Middlesex Update (oral)	EM	
5.2	Business Planning 2015/16 Outline Process	LB	
6	**ITEMS FOR INFORMATION**		
	QUALITY		
6.1	Quality Committee Minutes – 27 October and 24 November 2014	EH	
	GOVERNANCE		
6.2	Board Assurance Framework and Risk Report Q3	EM/ZP	
6.3	Register of Seals Report Q3	SY	
7	**ANY OTHER BUSINESS**		
8	**QUESTIONS FROM THE PUBLIC**		

9	**DATE OF NEXT MEETING – 26 February 2015**	
	CLOSE	**5.30**

Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Draft Minutes of the Public Meeting of the Board of Directors held on 30 October 2014/1.4/Jan/15
Purpose of paper	To provide a record of any actions and decisions made at the meeting
Decision/action required/ recommendation	The meeting is asked to agree the minutes as a correct record of proceedings The Chairman is asked to sign the agreed minutes
Summary of the key risks/issues from the paper	This paper outlines a record of the proceedings of the public meeting of the Board of Directors held on 30 October 2014.
Link to corporate objectives	NA
Non-Executive Sponsor	Sir Tom Hughes-Hallett, Chairman

Board of Directors Meeting, 30 October 2014 PUBLIC
Draft Minutes

Time: 4.00pm
Location: Chelsea and Westminster Hospital NHS Foundation Trust
Hospital Boardroom

Present

Non-Executive Directors	Sir Tom Hughes-Hallett	TH-H	Chairman
	Dr Andrew Jones	AJ	
	Eliza Hermann	EH	
	Sir John Baker	JB	
	Jeremy Jensen	JJ	
	Jeremy Loyd	JL	
	Karin Norman	KN	
	Nilkunj Dodhia	ND	
	Liz Shanahan	LS	
Executive Directors			
	Tony Bell	APB	Chief Executive
	Lorraine Bewes	LB	Chief Financial Officer
	Elizabeth McManus	EM	Chief Nurse and Director of Quality
	Robert Hodgkiss	RH	Interim Chief Operating Officer
In attendance			
	Rakesh Patel	RP	Director of Finance
	Susan Young	SY	Chief People Officer and Director of Corporate Affairs
	Dominic Conlin	DC	Director of Strategy and Integration

1 GENERAL BUSINESS

1.1 Welcome and Apologies for Absence — TH-H

TH-H welcomed the members of the public to the meeting.

Apologies were received from Professor Richard Kitney and Zoe Penn.

TH-H noted that it was Karin's and Richard's last Board meeting and thanked them for their valuable contributions and long service to Chelsea and Westminster.

1.2 Chairman's Introduction — TH-H

None.

1.3 Declaration of Interests — TH-H

There were no declarations of interests.

1.4 Draft Minutes of the Meeting of the Board of Directors held on 31 July 2014 — TH-H

Draft minutes of the previous meetings were approved as a true and accurate record.

1.5 Matters arising **TH-H**

TH-H noted that two matters arising listed in the paper were complete.

1.6 Chairman's Report **TH-H**

In addition to his written report TH-H noted that an election to fill in the vacant seats on the Council of Governors is in progress. The Board noted that there are two vacant seats in the patient constituency with 12 candidates standing for election; one vacant seat in the public constituency Royal Borough Kensington and Chelsea Area 2 with three candidates standing for election; and one vacant seat in the Support, Administrative and Clerical class of the staff constituency with three candidates standing for election. George Vasilopoulos, candidate in the Management class of the staff constituency and Diane Samuels, candidate in the Allied Health Professionals, Scientific and Technical class of the staff constituency, have been elected unopposed.

Voting for contested seats is due to take place from 6 to 27 November 2014 and the election results will be published on 28 November 2014.

TH-H said he welcomed the opportunity to attend the Care Quality Commission quality summit which was also attended by the Mayor of Kensington and Chelsea.

TH-H reported on a meeting with the Chairman of West London Clinical Commissioning Group (WLCCG). He has been invited to attend the five CCGs Chairs meeting.

TH-H said that in the spirit of getting to know each other he will invite the Non-executive Directors and Governors to taste some of his personal wine collection.

1.7 Chief Executive's Report **APB**

APB noted that the CQC report was published early in the week and it was shared with the Board and governors. The Trust had been provided with a draft report to which it provided a number of comments. It was noted that the CQC in their inspection report of Chelsea and Westminster under the new monitoring regime gave the overall rating of 'requires improvements'.

APB said that the report highlights 13 areas of excellence, however some of the findings indicate a need for improvement. Two key areas requiring improvement are standardisation of systems and processes.

Before the report publication a CQC quality summit was held to share findings with commissioners, stakeholders and staff. Separate staff briefings were held to share the findings.

In response to findings an action plan will be developed and will be submitted to the CQC by 28 November 2014.

APB noted that before the CQC report publication he had spoken with the local MPs and they were very supportive of Chelsea and Westminster.

APB highlighted that staff will be made aware of improvements required in their areas. He congratulated the Communications Team on managing the communications and press queries.

EM said that initially staff were surprised by the CQC findings, however, it has been recognised that services could improve. Staff will be involved in the service improvement reviews and the Trust plan effective engagement with stakeholders, the Board of Directors and Council of Governors will play a vital role in the drive for improvement in areas highlighted by the CQC.

Susan Maxwell commented on a concern from the CQC report in relation to matrons and sisters and suggested where necessary staff should undertake a leadership course.

JJ suggested that knowledge and experience of other foundation trusts which performed well in CQC inspection should be explored.

1.8 Council of Governors Report including Membership Report **TH-H**

TH-H said that pertinent issues were raised in his report earlier in the meeting.

TH-H congratulated Tom Pollak for presenting at the Annual Members' Meeting on behalf of the Council of Governors.

2 QUALITY

2.1 Patient Experience (video) **EM**

The Board noted the video of patient expressing her personal experience of her care at Chelsea and Westminster. EM thanked Charlotte Kirwan for sharing her experience in this way.

2.2 Safer Staffing **EM**

EM noted that she as the Chief Nurse on behalf of the Board carries out responsibility for nursing, midwifery and care staffing capacity and capability.

It was noted that demonstrating safer staffing is one of the CQC's six essential standards that Chelsea and Westminster has to comply with.

The Board agreed to provide support in relation to the realignment of budgets to existing staffing models. It supports the proposal for three supervisory days for ward sisters and noted in relation to risks that there are immediate remedial actions. It agreed to support development of a business case which will focus on further supervisory time and priority areas including nights.

ML said he would be delighted to see the role of ward sister being elevated.

EM noted that the staffing levels report will regularly come to the Board and these reports will be scrutinized by the Quality Committee.

In response to a comment from JJ regarding a recently broadcasted programme about A&E on Friday night, EM said that A&E departments are very busy on Friday night and the programme highlighted how busy A&E was on Friday night as

opposed to inadequate care.

Susan Maxwell commented on staffing in the AAU and the fact that they are shared between A&E and AAU which can create some issues of staff availability.

2.3 Ebola Update (oral) **EM**

EM noted that there are no Ebola patients in the UK and that the risk remains low.

The Board noted that NHS England requires that staff are prepared should anyone with potential symptoms turn up. There are Ebola posters in potential areas of where patients may enter. All staff are aware of practices in relation to protective equipment.

3 GOVERNANCE

3.1 Care Quality Commission Report (oral) **APB/EM**

This item was discussed earlier in the meeting.

3.2 Approval of the Terms of Reference of the Audit Committee **JB**

The Board noted that the terms of reference were reviewed by the Audit Committee and that no amendments were made.

The Board approved the terms of reference of the Audit Committee.

4 PERFORMANCE

4.1 Finance Report – September 2014 **LB/RP**

LB noted the financial position for September 2014, which was a deficit of £0.2m and £1.3m behind plan. The year to date position is a deficit of £0.8m, which is an adverse variance of £5.9m against a planned surplus of £5.1m. LB highlighted that one of the reasons for deficit is a high usage of agency staff.

LB flagged up that Chelsea and Westminster will continue with the surplus forecasted and the key to this is that the CIPs and agency staff expenditure are closely monitored. There are fortnightly meetings with the divisions and progress against targets is closely monitored. Some benefits have already been seen in expenditure after recently employing 80 nurses. The budget control is very tight in order to ensure a £3.4m surplus.

TH-H highlighted that delivering the budget will be very important in relation to the West Middlesex acquisition.

In response to a query from JB regarding £10m remaining unidentified CIPs, RP responded that Chelsea and Westminster has been very strict regarding identifying CIPs and where possible to deliver savings.

TH-H noted that consultants have also been asked to consider CIPs and a report is expected at the end of November 2014. Factors impacting on the deficit include the use of agency staff, admissions, length of stay and discharge of patients.

RP noted that the current deficit is impacting on the cash position and the cash

balance and that FT debt is £0.6m and Local Government debt £0.5m. Efforts will be put in collecting debt to improve the cash position.

TH-H said that the Board is determined to deliver year–end forecast of a £3.4m surplus and to maintain COSRR of 3.

4.2 Performance Report – September 2014 **RH**

RH noted that as at end September 2014 Chelsea and Westminster meets all performance targets with the exception of planned non-achievable Referral to Treatment Time (RTT) 18 weeks admitted and incomplete targets. It was noted that RTT admitted patients waiting time was due to dentistry recruitment.

Particular attention was drawn to pressures in A&E during Q2 and as indicated on p.10 of the report there has been an increase in A&E attendances.

In response to a question from JB regarding the staff vacancy rates SY said that some vacant posts are filled by agency staff and some by bank staff. Divisions have been asked to provide reasons for high level of vacant posts. SY noted that staff who leave state that the main reasons for leaving are due to promotion, relocation or undertaking further studies.

TH-H said that it would be useful to have a deep dive in this area.
Action: SY to explore this further and provide a deep dive report in staff recruitment and retention at the next Board. **SY**

EH congratulated RH on a well written performance report.

4.3 Monitor In-Year Reporting & Monitoring Report Q2 **LB**

Noted.

5 STRATEGY

5.1 West Middlesex Update **APB/DC**

APB noted that the West Middlesex Acquisition Project is currently under the review of the Competition and Markets Authority. Upon successful review, the Full Business Case will then be submitted to the Board.

APB noted that the Trust is considering the option of extending the transaction deadline. This is due to our recent learning that the CQC inspection of West Middlesex is due to take place in November 2014 and the report is expected in February/March 2015.

Work on the Full Business Case continues, however, the transaction timeline might have to be adjusted. APB highlighted that the main part of the business case is the proposal to put in place a new electronic Patient Record and integrated IM&T systems across both sites and the benefits that this would offer will be considered.

Royal Brompton Hospital
APB noted that the Board to Board meeting took place in September at which a joint venture for women and children's services was considered. Work on this continues.

The Board noted that Simon Eccles has been appointed as Associate Medical

Director for Maternal and Child Health Services.

In response to a question from Tom Pollak TH-H said that it is yet to be seen what the CQC report of West Middlesex will identify and this is likely to impact on the acquisition project. TH-H clarified that Chelsea and Westminster recently learned about the planned CQC inspection of West Middlesex.

APB added that other factor impacting on the acquisition project timetable is the general election.

5.2 Research and Innovation Strategy 2014-19 **DB/APB**

APB noted that due to Professor Derek Bell being unable to attend this item will be deferred to the next meeting.

TH-H noted that the Board is of a view that the research and education are two important fields to focus on. This also presents an important strategic opportunity.

Research and innovation to come to a future Board. **Action: APB to bring research and innovation to a future Board**. **APB**

6 ITEMS FOR INFORMATION

6.1 Assurance Committee Report and Minutes – June, July and September 2014 **KN**

Noted.

6.2 Infection Control Annual Report 2013/14 **EM**

Noted.

6.3 Board Assurance Framework and Risk Report Q2 **APB/EM**

Noted.

6.4 Register of Seals Report Q2 **SY**

Noted.

6.5 Proposed Board meeting dates for 2015 (to be tabled **TH-H**

TH-H noted that the future dates will be emailed to the Board members.

6.6 Fit and Proper Person Test and Duty of Candour **SY**

TH-H noted two new regulatory requirements, fit and proper person requirement for Board directors and duty of candor, which are likely to apply from November 2014.

6.7 Audit Committee Minutes – 8 July 2014 **JB**

Noted.

7 ANY OTHER BUSINESS

APB noted that a power outage happened earlier in the morning. Provisions were

put in place to maintain the services. The power outage will impact on the electricity bill.

APB thanked Norlands and the Estates Department for ensuring hospital services were not interrupted.

8 QUESTIONS FROM THE PUBLIC

Questions from the public were taken during the course of the meeting.

9 DATE OF NEXT MEETING – 29 January 2015

Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Matters Arising/1.5/Jan/15
Purpose of paper	To provide a record of actions raised and any subsequent outcomes from the October Public Board of Directors Meeting.
Decision/action required/ recommendation	The Board is asked to note the actions or outcomes reported by the respective leads.
Summary of the key risks/issues from the paper	This paper outlines matters arising from the public meeting of the Board of Directors held on 30 October 2014.
Link to corporate objectives	NA
Non-Executive Sponsor	Sir Tom Hughes-Hallett, Chairman

Board of Directors Meeting, 30 October 2014 Public

Ref	Description	Lead	Subsequent Actions/Outcomes
4.2/Oct/14	**Performance Report – September 2014**		
	Action: SY to explore this further and provide a deep dive report on staff recruitment and retention at the next Board.	**SY**	On agenda
5.2/Oct/14	**Research and Innovation Strategy 2014-19**		
	Action: APB to bring research and innovation to a future Board.	**APB**	The new People Committee will provide assurance to the Board on education and training. Research and Innovation Strategy led by Professor Derek Bell to be scheduled for later this year.

Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Interim Chief Executive's Report/1.8/Jan/15
Purpose of paper	This paper is to provide an update to the Board on key issues
Decision/action required/ recommendation	For information
Summary of the key risks/issues from the paper	This report is a summary of focus and priority for the Interim Chief Executive. It highlights key issues to note. Risks are discussed along with mitigations later in the agenda.
Link to corporate objectives	All
Executive Sponsor	Elizabeth McManus, Interim Chief Executive

Interim Chief Executive's Report

This is my first Board of Directors Meeting as Interim Chief Executive having been in post since 20 November 2014 when Tony Bell stepped down. I was fortunate to have had some handover time with him prior to him starting a new role at NHSE.

Our focus for the next 6 – 9 months is on ensuring we continue to have operational grip whilst at the same time having a targeted growth agenda and remembering that this is a people based organisation.

Grip

Performance – The Chief Operating Officer will report an improving recovery position in the Performance & Quality report for December 2014 for Referral Treatment Time & Emergency Department 4 hour position.

Care Quality Commission Action Plan - this plan and our actions are alive and we have already completed many of them since October. The plan is discussed at every management meeting each week and actions updated accordingly. Key to success of the action plan is ensuring that people take responsibility for making changes quickly. The Quality Committee is responsible for ensuring this plan is fully implemented and any key risks understood and mitigated.

Financial Position - the financial challenges remain more significant than ever before. We have taken a big decision to employ external turnaround expertise to drive demonstrable increased grip on driving up our CIP contribution. This will herald a different level of engagement with staff in some of the areas where we see the most potential benefit:

- Theatres
- Outpatients
- High cost temporary staffing

This will better support knowledge or capacity gaps and ensure that we learn quickly to embed even better discipline with our precious resources.

The recent quarterly "business bilaterals" with each of the divisions gave me increased confidence in every division meeting their financial challenges this year; however the Trust will nevertheless carry forward an underlying deficit position into 15/16. The Finance and Investment Committee will consider the opening budget position in both its January and February meetings before presentation to the Board in February.

Growth

We have prioritised fewer strategic possibilities in order to deliver both today's business and a successful transaction with WMUH as well as full participation in the SAHF programme – not least of which is our £10 million Emergency Department redevelopment, which is well underway.

West Middlesex University Hospital (WMUH) - as you will be aware, we have been working towards a single merged organisation over the last 2 years. The acquisition will improve the quality of care across both hospital sites, with more flexibility, clinical staffing and physical space to develop services. This gives both organisations scale and an opportunity to expand services on both sites, as well as creating a more resilient organisation. We want to make this partnership a reality by July 2015. The acquisition will help us to attain the expected

standards around 7 day working and the London Quality standards. Over the last week all parties have progressed to the signing of Heads of Terms, which means all Boards have signed off their commitment to the merger. Over the next 22 weeks we will be working increasingly closely to ensure the joint organisation starts on the best foot.

You will note that the deadline is slightly later than what was originally proposed (1 April 2015). This is because we need to make sure that any clinical issues that come out of both of our CQC reports form part of our Full Business Case, which will also detail financial stability for the new organisation. Given the Board of Directors approve the Full Business Case in February we will still need approval from Monitor, our Council of Governors and the Secretary of State for Health. We are pleased to say that the Competition Markets Authority has given their go-ahead for the transaction. Other key stakeholders such as the CCGs and Local Authorities will hold us to account to ensure that the proposed acquisition will have a positive effect on the communities they are responsible to.

People

As Interim Chief Executive I have been encouraged by the progress we are making with our external partners, their increasing confidence in our ability to deliver the agenda ahead.

This is in part as a result of strengthening the management capacity available to ensure we are able to deliver at pace.

We have already appointed:

- An Interim Director of Quality & Governance
- An Interim FT Board Secretary
- Specialists to work alongside us in speeding up our rate of financial recovery & delivery of the work programme over the next 6 months
- An Integration Director (WMUH)
- A Commissioning & Contracting Director

The benefits need to be seen quickly and I want to ensure that whilst external experts help us immediately, they leave us with the skill, culture and confidence to continue to deliver at pace.

I am delighted that a People Committee is being established and that their first task will be to review work this far on the people strategy and shape work plan going forward.

Stakeholder Engagement

Since coming in to post I have met with a number of our key stakeholders:

– Patients…. On my walkabouts
– Governors
– Lots of Staff
– Cllr Freeman and Cllr Faulks – Royal Borough of Kensington and Chelsea
– James Reilly CEO and Pam Chesters – Chair – CLCH NHS Trust
– Tony Bourne and Mark Norbury – Chelwest Health Charity
– Daniel Elkeles – Director of Strategy – NW London
– Alwen Williams – Director of Delivery and Development – NHS TDA
– Simon Weldon – Regional Director London Operations and Delivery – NHS England
– Adrian Bull – Imperial College Healthcare Partners
– Sue Jeffers CEO and Board – Hounslow CCG

– Marion Smith Head of Quality – NHS TDA
– Adult Social Care and Health Scrutiny Committee
– Cally Palmer CEO – The Royal Marsden
– Dame Jaqueline Docherty CEO – West Middlesex Hospital

Finally

I have made some small yet significant changes focussing particularly on the active leadership of the organisation, with a new style of team brief, more frequent leadership walk rounds and encouraging people to make decisions quickly.

I am thoroughly enjoying the job, have a great team and am enjoying the support afforded by so many of you

Elizabeth McManus
Interim Chief Executive

Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Council of Governors Report including Membership Report/ 1.9/Jan/15
Purpose of paper	Part A – provides highlights of the Council of Governors meeting held on 4 December 2015 Part B – updates the Board on membership numbers Part C – provides an update of the Autumn 2014 Quality Award winners
Decision/action required/ recommendation	For information.
Summary of the key risks/issues from the paper	This paper highlights the pertinent issues discussed at the Council of Governors meeting held on 5 December 2015 and the updates the Board on membership numbers.
Link to corporate objectives	NA
Non-Executive Sponsor	Sir Tom Hughes-Hallett, Chairman

Part A

Council of Governors Report

1.0 Announcement of results of election

It was noted that there were six newly elected governors. Importance of new governors to 'buddy up' with existing governors to ensure smooth transition into the role was noted.

2.0 Chairman's report

The departure of Tony Bell and his contribution to the Trust over the past few years were noted. The interim arrangements for the post of Chief Executive were discussed with Libby McManus, Chief Nurse and Director of Quality.

It was noted that the priority was to make a clear decision on integration with the West Middlesex. In relation to that the clinical summit was held earlier in December which presented the opportunity for clinicians from both Chelsea and Westminster and West Middlesex to discuss what services could look like in a new unified organisation. The West Middlesex CQC report will be important to the clinical case for change. A specific governor workshop about the West Middlesex PFI was scheduled for 15 December.

3.0 Chief Executive's report

It was noted that the Trust's A&E performance and the importance of patients accessing the right health service over the winter period to help alleviate pressures being experience in by A&E s across the country.

It was noted that the funding for Shaping a Healthier Future (SAHF) remains same as defined in February 2013 and each Trust submitted the business case to deliver SAHF and the central team are reviewing each case to ensure that they deliver on implementation and are affordable.

4.0 CW+ update

An update on the CW+ was received from Mark Norbury, CW+ Chief Executive.

5.0 CQC announced inspection results and action plan

The governors received highlights of the action plan submitted to the CQC on 28 November. The progress against the plan will be monitored by the Quality Committee and an update will be provided to the governors at the next meeting.

6.0 West Middlesex update

It was noted that the Full Business Case will be presented to governors which will place particular emphasis on better care that could be provided at both sites following integration.

7.0 Re-appointment of Non-executive Directors

The Council of Governors agreed the extension of Sir John Baker's term of office for a period of one year.

It was noted that the appraisal of Jeremy Loyd could not take place in time for the meeting. The Council of Governors agreed the approach that upon a completion of Jeremy's appraisal a paper will be brought to the next meeting.

8.0 Council of Governors Performance Evaluation – proposed questionnaire

It was noted that this was a statutory requirement for governors to evaluate their performance annually.

9.0 Open Day 2015

The governors noted the paper details a proposal for the open day 2015. It was highlighted that the day will focus on the safe value in light of the continued focus on staff on fulfilling the recommendations outlined in the CQC report.

Part B

Membership Report

1.0 Membership joiners and leavers October –December 2014 (Q3 2014/15)

Totals	Oct	Nov	Dec
Period Start	**15,114**	**15,023**	**15,021**
Joiners	26	8	0
Leavers	117	10	4
Period End	**15,023**	**15,021**	**15,017**

Public	Oct	Nov	Dec
Period Start	**5,543**	**5,515**	**5,513**
Joiners	14	3	0
Leavers	42	5	2
Period End	**5,515**	**5,513**	**5,511**

Patient	Oct	Nov	Dec
Period Start	**6,177**	**6,114**	**6,115**
Joiners	10	5	0
Leavers	73	4	2
Period End	**6,114**	**6,115**	**6,113**

Staff	Oct	Nov	Dec
Period Start	**3,394**	**3,394**	**3,393**
Joiners	2	0	0
Leavers	2	1	0
Period End	**3,394**	**3,393**	**3,393**

Figure 1.0 Overall Members Ethnicity Q3 2014/15

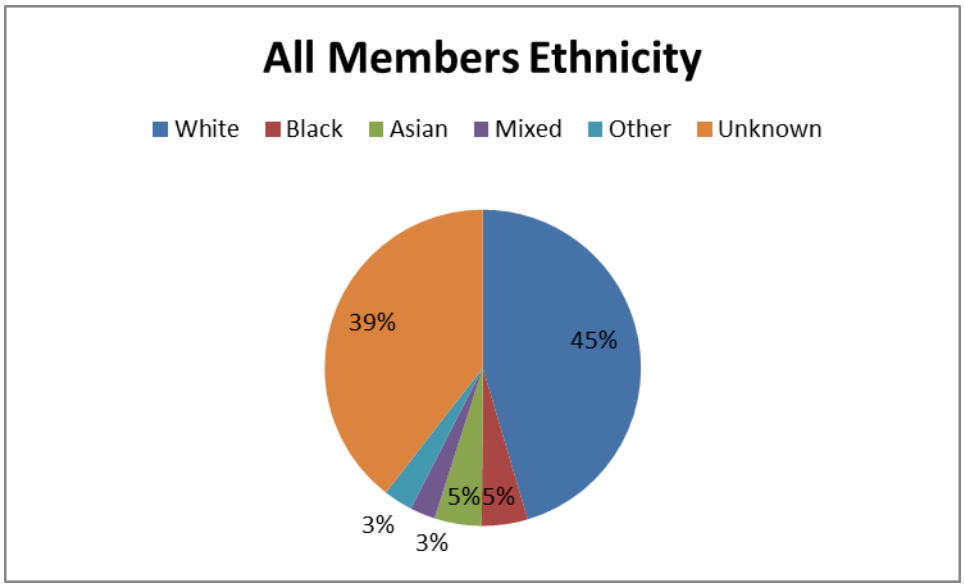
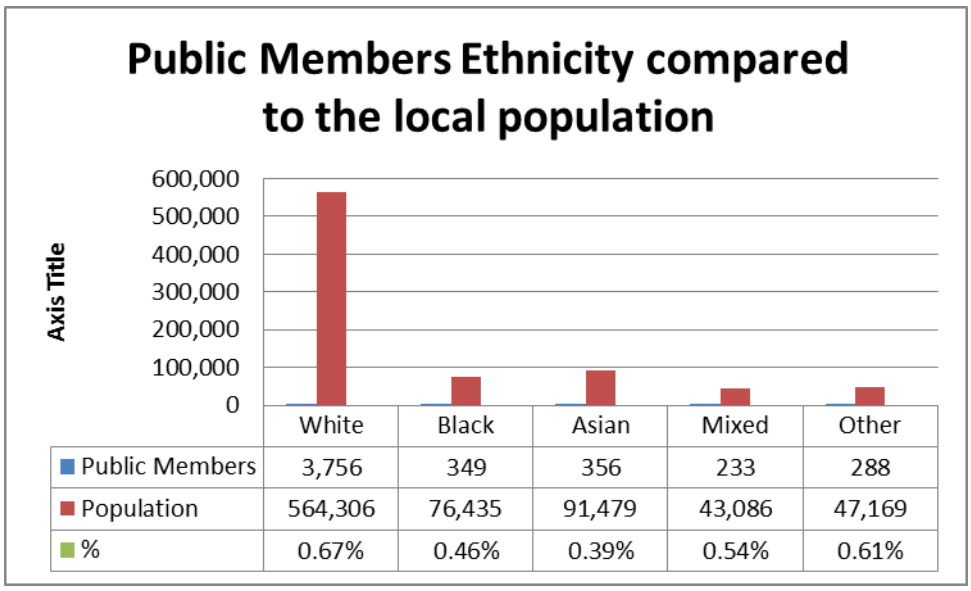
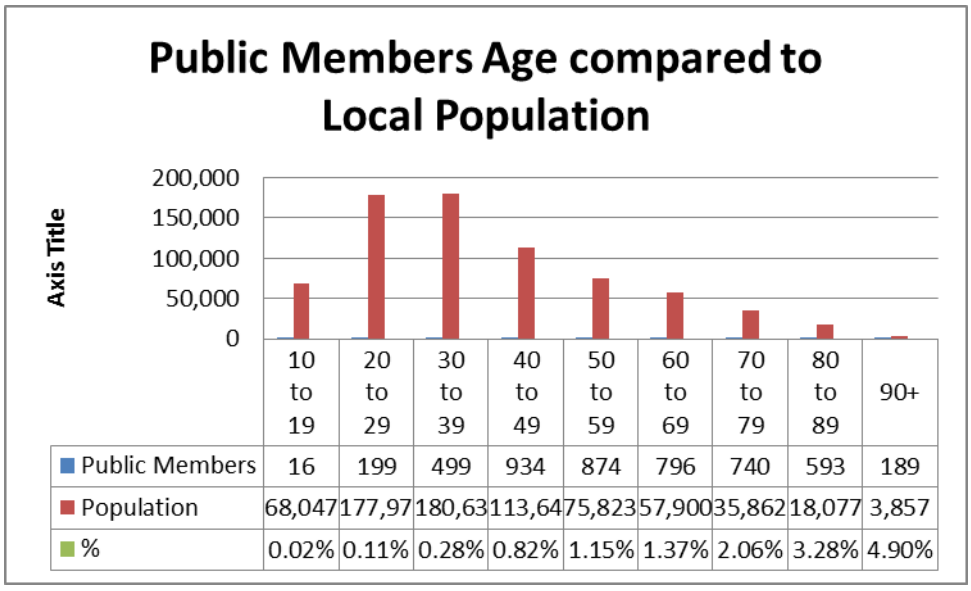


Figure 2.0 Public Membership Comparisons to the Local Population Q3 2014/15



	White	Black	Asian	Mixed	Other
Public Members	3,756	349	356	233	288
Population	564,306	76,435	91,479	43,086	47,169
%	0.67%	0.46%	0.39%	0.54%	0.61%

Figure 3.0 Public Membership Age Q3 2014/15



	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90+
Public Members	16	199	499	934	874	796	740	593	189
Population	68,047	177,97	180,63	113,64	75,823	57,900	35,862	18,077	3,857
%	0.02%	0.11%	0.28%	0.82%	1.15%	1.37%	2.06%	3.28%	4.90%

Figure 3.1 Overall Membership Age Groups Q3 2014/15

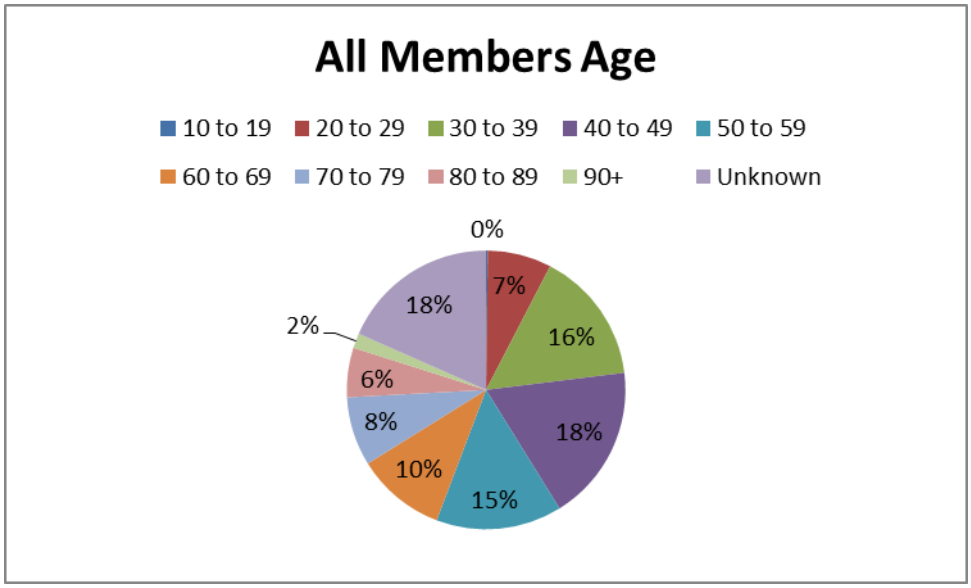
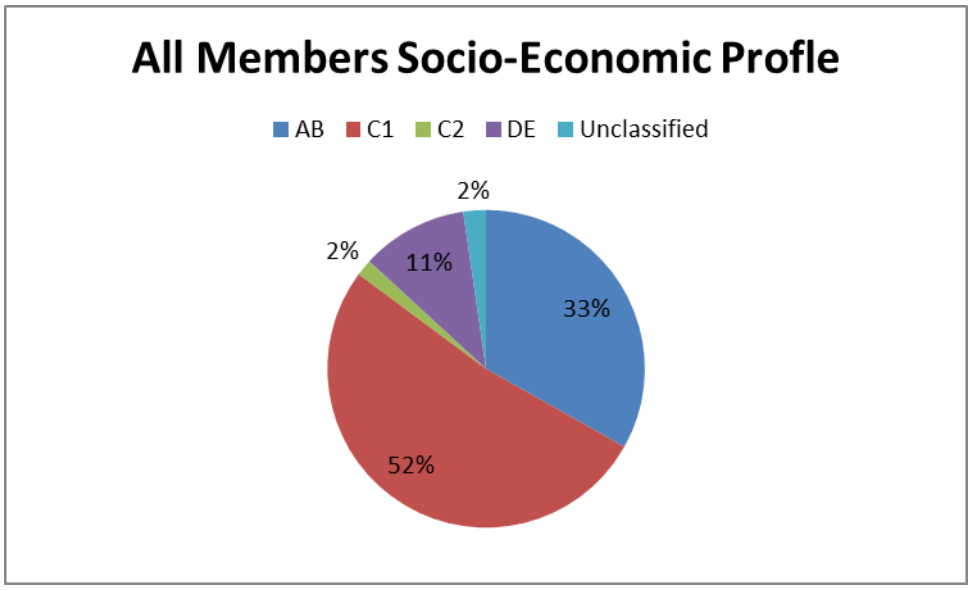


Figure 4.0 Overall Membership - Socio-Economic Groups* Q3 2014/15



*Social economic grade: A-upper middle class (higher managerial, administrative or professional occupation, B-middle class (intermediate managerial, administrative or professional occupation), C1-lower middle class (supervisory or clerical, junior managerial, administrative or professional occupation), C2-skilled working class (skilled manual workers), D-working class (semi and unskilled manual workers) and E-those at the lowest level of sustenance (state pensioners or widows (no other earner), casual or lowest grade workers).

PART C

Council of Governors Quality Awards

The Autumn Council of Governors Quality Awards winners were as follows:

- Dementia Care Initiatives
- Nuclear Medicine Department
- Maternity Baby Friendly

Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Trust Health & Safety Policy/2.1/Jan/15
Purpose of paper	There is a statutory requirement to have an up to date, accurate and relevant health and safety policy in place. The policy should be discussed and ratified by the board. The policy was reviewed and endorsed at the Health Safety & Fire Committee in November 2014.
Decision/action required/ recommendation	The Board are asked to consider and ratify the content of the reviewed policy.
Summary of the key risks/issues from the paper	This is an annual review of the Trust policy and includes minor changes to reflect organisational structure changes including: • Replacing the Assurance Committee with the Quality Committee • Adding the specific role of the Divisional Nurse, Matron Ward Manager and Local Security Management Specialist.
Link to corporate objectives	Health & Safety
Executive Sponsor	Vanessa Sloane, Interim Director of Nursing

Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Trust Health & Safety Policy/2.1/Jan/15 – supporting paper
Purpose of paper	There is a statutory requirement to have an up to date, accurate and relevant health and safety policy in place. The policy should be discussed and ratified by the board. The policy was reviewed and endorsed at the Health Safety & Fire Committee in November 2014.
Decision/action required/ recommendation	The Board are asked to consider and ratify the content of the reviewed policy.
Summary of the key risks/issues from the paper	This is an annual review of the Trust policy and includes minor changes to reflect organisational structure changes including: • Replacing the Assurance Committee with the Quality Committee • Adding the specific role of the Divisional Nurse, Matron Ward Manager and Local Security Management Specialist.
Link to corporate objectives	Health & Safety
Executive Sponsor	Vanessa Sloane, Interim Director of Nursing

HEALTH AND SAFETY POLICY

START DATE:	January 2015	**NEXT REVIEW:**	December 2015
COMMITTEE APPROVAL:	Trust Board	**CHAIR'S SIGNATURE:**	
	DATE: January 2015		
	ENDORSED BY: Health, Safety & Fire Committee	**DATE:** November 2014	
DISTRIBUTION:	Trustwide		
LOCATION:	Intranet: Trustwide Policies and Procedures		
RELATED DOCUMENTS:	Trust Risk Management Strategy and Policy, Trust Incident Reporting Policy, Risk Management Strategy, Trust Fire Policy, Moving & Handling Policy, Infection Control Policy, Security Policy, First Aid Policy, Control of Contactors Policy, Smoke Free Policy, COSHH Policy, Stress Policy, Management and Prevention of Body Fluid Exposure Policies, Slips Trips & Falls Policy, Security Policy, Lone Working Policy, Display Screen Equipment Policy, Waste Policy, Latex Policy and New & Expectant Mothers Policy		
AUTHOR / FURTHER INFORMATION:	Kevin Ray, Health & Safety Consultant Holly Ashforth, Interim Deputy Chief Nurse		
STAKEHOLDERS INVOLVED:	Health & Safety Committee members		

DOCUMENT REVIEW HISTORY:

Date	Version	Responsibility	Comments
February 2005	1	Health & Safety Consultant	Review
February 2007	2	Health & Safety Consultant	Review
August 2008	3	Health & Safety Consultant	Review
November 2009	4	Health & Safety Consultant	Review
January 2010	5	Health & Safety Consultant	Review
February 2011	6	Health & Safety Consultant	Organisational change
August 2012	7	Health & Safety Consultant	Organisational changes reflecting Divisional structure. RIDDOR changes for reporting absence of more than 7 days.
July 2013	8	Health & Safety Consultant	Yearly review
October 2014	9	Health & Safety Consultant	Organisational change with HSFC reporting to Quality Committee. Addition of the role of Divisional Nurse, Matrons, Ward Managers and the Local Security Management Specialist (LSMS)
DATE EXPIRED:	**April 2016**		

Contents

1. Policy Statement

The Chief Executive and Board of the Chelsea and Westminster Hospital NHS Foundation Trust are committed to providing and maintaining, so far as reasonably practicable, a safe and healthy environment for all employees, contractors, patients, visitors and those who may be affected by work related activities. The Trust regards the promotion and progressive improvement of health, safety and welfare at work as a mutual objective for management and employees at all levels. The Trust recognises that the only effective approach to the prevention of injury and loss is the systematic identification and control of risk through the Trust's risk assessment process, the adoption of best practice in health and safety management and the allocation of necessary resources.

The Health and Safety Policy is intended to confirm the management arrangements which are designed to ensure the health and safety of anyone who could be adversely affected by the activities of the Trust. In recognition of the obligations imposed under the Health and Safety at Work Act, the following policy has been prepared. The policy will be reviewed annually or when legislation, codes of practice and official guidance dictate.

The executive responsibility for the management of health and safety for the Trust has been delegated by the Chief Executive to the Director of Nursing and Quality, with advice and support from the Trust's Health and Safety Consultants, Occupational Health Services Manager, Infection Control, Risk Managers, Fire Consultant and the Director of Estates & Facilities. However, the Trust regards the promotion of health, safety and welfare at work as a mutual objective for management and employees at all levels.

To maintain and promote the implementation of this policy and enable employees to function efficiently with regard to health and safety; information, instruction, training and supervision will be provided in accordance with identified needs.

The Trust has a Health, Safety & Fire Committee which comprises management, staff representatives and site partners to ensure good and effective communication.

Whilst overall responsibility to provide and maintain safe and healthy working conditions, equipment and systems of work rests at the highest level of management, every individual has a responsibility to prevent personal injury and damage to property and to protect everyone from foreseeable work hazards, including the public insofar as they come into contact with Trust premises and services.

Signed: **Date:**

Chief Executive

On behalf of the Chelsea and Westminster Hospital NHS Foundation Trust

2. Introduction

The Trust will manage health and safety using the process of risk management which includes the identification of hazards, assessment of risks and introduction of control measures. To ensure this the Trust will:

- Adopt a systematic approach to safety. This includes following any standards published by the Health & Safety Executive, NHS or Department of Health which identify priorities and set objectives whereby risks are eliminated or minimised by the correct selection and design of facilities, equipment and processes;

- Provide and maintain safe and healthy working conditions, adequate welfare facilities, safe means of access and egress taking account of all statutory requirements and proactively help staff manage their own wellbeing;

- Provide information, operational policies and procedures, training, instruction and supervision to enable employees to perform their work safely and efficiently;

- Make available all necessary safety devices and protective equipment and provide instruction in their use;

- Maintain a constant and continuing interest in health, safety and welfare matters by consulting and involving employees or their representatives;

- Liaise with other employers upon its sites insofar as the activities of these employers affect the health, safety and welfare of the Trust's staff, students visitors and patients; and where the activities of the Trust may affect the activities of the other employers;

- Carry out a risk assessment when planning new developments, systems of work and when purchasing new equipment;

- Keep and maintain accurate records of accidents, incidents and injuries;

- Evaluate the application of Trust Health & Safety related policies and procedures.

- Ensure that arrangements are in place for patient and Service Users engagement.

3. Organisation and Responsibilities

Boards and Committees

3.1 The Trust Board

In the context of effective corporate governance, management of health and safety risks is a key issue for the Board, who have a collective role in providing committed leadership in the continuous improvement of health and safety performance. The Board will ensure that their actions and decisions always reinforce this commitment, and that they will review the effectiveness of the health and safety management system and performance, at least annually via the Quality Committee which is a sub committee of the Board.

The Board has a specific responsibility under the Health and Safety at Work etc Act, to prepare a General Policy statement and all staff are expected to comply with this policy, as outlined in the statement.

The Board has a monitoring, review and policy setting role in health and safety.

3.2 Quality Committee

This is a sub committee of the Board and its aim is to seek assurance on systems, processes and outcomes relating to quality (patient safety, effectiveness and patient experience), staff satisfaction and safety and the environment, and assuring compliance with the Care Quality Commission Standards. It is responsible for assuring the Board that there are effective systems in place for health and safety. It receives a monthly report on health and safety and provides a monthly report on all areas considered to the Board.

3.3 Risk Management Committee

The Risk Management Committee is responsible for ensuring that proactive, progressive and continuous improvement in the Trust's approach to risk management is achieved. This includes overseeing the development and maintenance of a risk register and associated risk management processes.

3.4 Health, Safety & Fire Committee

The Health, Safety & Fire Committee is responsible for ensuring the development and implementation of a Health & Safety Policy and safety management systems for dealing with safety risk issues, and for encouraging and fostering greater awareness of safety risk management throughout the Trust at all levels. The Health, Safety & Fire Committee will receive regular reports from the safety sub-groups, Radiation Safety Committee, Medical Gas Committee, Sustainability Committee (waste and environment) and Fire Action Group.

Individual Post Holders

3.5 The Role of the Chief Executive

The Chief Executive has prime overall responsibility for Health and Safety. The duty to implement Health and Safety Regulations has been delegated to the Chief Nurse. The Chief Executive will ensure:

- Appropriate management arrangements exist for the Trust to comply with the requirements of health and safety legislation in maintaining and implementing this policy;
- That so far as is reasonably practicable adequate resources will be provided to meet the requirements;
- All managers identified within this policy understand and discharge their specific health and safety responsibilities.

3.6 The Role of the Director of Nursing and Quality

The Director of Nursing and Quality will:

- Chair the Health, Safety & Fire Committee
- Ensure that the Health & Safety policy is reviewed annually or earlier as appropriate;
- Promote a healthy, safe environment by effective communication and coordination on matters of health and safety;
- Ensure that health and safety is given a sufficiently high profile to maintain a culture which encourages effective health and safety management;
- Support the Chief Executive in relation to corporate health and safety responsibilities.
- Ensure that staff have access to fire safety advice as part of their induction and to a range of health and safety related training as required to undertake their roles.

3.7 Health and Safety Consultants

Health and safety consultants provide advice on general Health and Safety, support Trust management and monitor and advise on safety performance. The Health and Safety Consultants have a co-ordinating role in relation to general safety issues including delivering health and safety training, review of risk assessments including COSHH and audit of the Trust's arrangements for managing health and safety.

The duties and responsibilities are:

- on a day-to-day basis to assist the Trust in ensuring, as far as is possible, that activities comply with the necessary legislation and to advise the management on safety matters, to ensure that the Trust's procedures for caring for the health, safety and welfare of its staff and students are of the highest standard and that the health, safety and welfare of the general public is not adversely affected by the Trust's activities;

- to act as the Fire Safety Advisor as required by the NHS Firecode to support the Fire Safety Manager;

- to act as the secretary of the Health, Safety & Fire Committee and follow up any recommendations made;

- to provide on behalf of the Fire Safety Manager training and instruction of staff and students in respect of safety and fire prevention, and to keep them conscious of the problems of safety, and of their responsibility for the safety of those with whom they work;

- to carry out health & safety audits of each department at appropriate intervals and provide a report to department managers and safety committees;

- to obtain, where appropriate, expert external advice to ensure that the safety procedures in operation are of the highest necessary standard;

- to act directly as advisor to managers and members of staff on safety matters and, where necessary, to obtain expert advice on their behalf;

- to liaise on behalf of the Trust with the enforcing authorities on all safety & fire issues.

- to flag significant concerns and non-compliance

The Safety Consultants can be contacted by telephone on 58656 or by email at **Safety.officer@chelwest.nhs.uk**

3.8 The Role of the Trust Executive Directors

The Trust Executive Directors will be accountable to the Chief Executive for ensuring safe and healthy working conditions. Executive Directors will provide appropriate support to managers within their Divisions to meet their responsibilities for health and safety.

3.9 The Role of Divisional Medical Directors, Divisional Directors of Operations and Divisional Nurses

Divisional Medical Directors, Divisional Directors of Operations and Divisional Nurses will implement this policy within their Divisions by operating a safety culture and ensuring adequate communication, training and assessment and monitoring of risks. In particular, this will include:

- Ensuring sufficient suitable staff are identified within their Division to carry out the roles of Safety Coordinator, COSHH Assessors, Fire Marshall and Radiation Protection Supervisors, as appropriate. The Safety Consultant maintains the list of nominated individuals who have attended the relevant training sessions.

- Ensuring that annual health and safety objectives are defined with key indicators and success criteria established to monitor performance within their Division.

- Ensuring that Trust health and safety key performance indicators are met and plans developed in the Division to address shortfalls.

- Ensuring that annual budget reviews identify adequate resources and facilities to enable achievement of these objectives.

- Ensuring that mandatory training identified in the Trust training needs analysis is undertaken in the Division.

- Obtaining commitment from their managers to the health and safety risk management system and encouraging them to foster health and safety consciousness, including developing local health and safety policies and procedures within the overall General Statement of Policy published by the Trust.

- Developing, maintaining and reviewing annual Comprehensive Risk Reviews as set out in the Trust's Risk Management Policy, which reflect local risks and other issues.

- Ensuring that all incidents, whether injury is sustained or not, are reported and fully investigated, that immediate and underlying causes are identified and recorded, and that appropriate remedial action and lessons are learned and longer-term objectives relating to health and safety are introduced.

- Ensuring that reports from the HSE and other similar sources relating to their Division receive prompt attention and appropriate action.

3.10 The Role of Department Managers, Ward Managers, Matrons and Supervisors

- To undertake a health and safety audit once a year, ideally in consultation with the local health and safety representative, prioritising risks identified and developing risk treatment plans to eliminate or minimise exposure. Where risks cannot be eliminated, developing written safe systems of work and ensuring that staff are aware of them through training and supervision. Maintaining a local Risk Register to record assessment outcomes.

- Nominate a Safety Coordinator and sufficient Fire Marshalls for each ward/department. To support the Coordinator/Marshall and ensure they are trained.

- Identify potential occupational health and safety hazards involved in their operations and the precautions to be taken and record those precautions.

- Identify actual and potential hazards at work and ensure either their removal, where possible, or that risk is minimised.

- Produce and update appropriate local Health and Safety Policies, procedures and assessments. Ensuring that these are available to all requiring them.

- Ensure that all relevant policies, procedures and assessments are brought to the attention of, and made available to, staff under their control, and that appropriate warning notices and all instructions are prominently displayed.

- Ensure that staff comply with mandatory health and safety training identified in the Trust training needs analysis.

- Ensure that local induction, and refresher training on health and safety issues is provided, covering policies/procedures, safe systems of work and safe operation of equipment.

- Ensure that all staff are made aware of Trust and Departmental safety policies and procedures, hazards and any other safety information, which they require in order to perform their duties safely.

- Ensure that all appropriate health and safety equipment, protective clothing etc is always available, properly maintained and used.

- Ensure that all supervisors understand instructions regarding health and safety, monitoring staff compliance.

- Investigate and record all accidents/dangerous incidents within their area of control and ensure that any remedial action is implemented as soon as possible reporting to their Director/General Manager as appropriate.

- Ensure that equipment used in the department is safe and adequate for the purpose for which it is intended.

- Ensure that faulty equipment, plant or buildings are reported promptly for repair and adequate steps are taken to put the relevant unit or area out of use in the interim should this be considered necessary.

- in conjunction with the Occupational Health Department, to maintain where appropriate departmental First Aid arrangements to the required standard;

3.11 The Role of the Safety Coordinators

Safety Coordinators are appointed by Ward or Department Managers. Safety Coordinators assist the Manager to meet their health and safety responsibilities.

The duties are:

- to understand and apply the Trust's Health and Safety Policy, its guidelines and procedures, as well as the Departmental Health and Safety Policy;

- to liaise with the Manager and Safety Consultant and other health & safety representatives, including representing their Department at the Health, Safety & Fire Committee as required;

- to inform and liaise with the manager to identify training needs, organise training where appropriate, and maintain training records within the department;

- to maintain the local Safety Manual, and other related policies;

- to review at regular intervals all local Health and Safety Policies and operational procedures and advise the Manager when changes are necessary;

- to monitor plant, equipment, processes, working practices, procedures and standards of housekeeping to ensure that they are safe;

- to assist the manager in the preparation of risk assessments;

- to distribute Health and Safety information and draw to the attention of staff particular areas of relevance to work procedures;

- to carry out local safety inspections and maintain records;

- to monitor the selection, use, maintenance and replacement of personal protective equipment (PPE);

- to refer promptly to the manager and the Health and Safety Consultant, any health and safety problems which cannot be resolved locally on a timescale appropriate to the risk;

- to ensure that staff, agency and visiting workers within their areas are familiar with accident procedures, fire precautions and first aid arrangements.

3.12 The Role of the Human Resources and Training and Development Departments

- To ensure all job descriptions define the post holders' responsibilities in relation to health and safety

- To ensure that health and safety training is accommodated within the Trust's training programme

- To ensure that the philosophy of accident and ill health reduction by good management and working techniques is promoted throughout the Trust

- To maintain a computerised database of staff who have received mandatory training throughout the Trust – to include induction; statutory training and ad hoc health and safety courses provided by the Trust.

- To provide reports for managers on compliance against the mandatory standards described in the Trust training needs analysis.

3.13 The Role of Safety Representatives

Safety Representatives may be appointed by recognised Trade Unions and Professional Organisations in accordance with the Safety Representatives and Safety Committees Regulations as modified by the Management of Health and Safety at Work Regulations and the Health and Safety (Consultation with Employees) Regulations.

Their role and functions under the Regulations are recognised by the Trust and they will be afforded the necessary time off with pay to attend any necessary courses and meetings as laid down in the Trust's Time Off for Trade Union Duties/Activities Policy.

A list of currently recognised Trade Unions is maintained and updated as necessary by the Director of Human Resources.

3.14 The Role of Every Member of Staff

All employees have a duty to themselves, colleagues, and to any person who might be affected by their actions, to work in a safe manner. In particular this will include:

- taking reasonable care for the health and safety of themselves and any other person who may be affected by their acts or omissions;

- Cooperating with managerial and supervisory staff to ensure that all relevant statutory regulations, policies and procedures are followed.

- Attending as directed, health and safety training sessions designed to further the cause of health and safety, and increase individual awareness;

- Ensuring that where required, safety equipment/devices are used as directed and appropriate protective clothing is worn.

- Reporting to their manager/supervisor all faults, hazards, unsafe practices, accidents, adverse incidents, dangerous occurrences and near misses whether injury is sustained or not;

- Ensuring that any ill health or medical condition, which may affect their ability to work safely, is reported immediately to their line manager and /or the Occupational Health Department;

- Reporting to their manager any incident of somebody intentionally interfering with, or misusing any equipment or material provided to ensure a healthy and safe environment.

3.15 Contractors

All contractors engaged by the Trust (or their nominated contractors e.g. Norland Managed Services and ISS Mediclean) have a responsibility, as specified in all contract documents to carry out their work in a safe manner in respect of their own staff, sub-contractors, Trust staff and premises, patients and member of the pubic. The Trust policy Controlling Contractors provides further detail.

The Trust will ensure so far as is reasonably practicable, employment of competent contractors who are able to demonstrate that they have in place management systems for safely undertaking work for which they have been employed.

3.16 Specialist Advisors

These are employees working within, or managing a department with the Trust and who have designated responsibilities for advising on and ensuring the implementation of Health and Safety measures. Managers within the Trust should refer to these advisors on matters relevant to their speciality, and for assisting in investigating adverse incidents and near misses, and identify solutions to prevent reoccurrence. These are listed below:

3.16.1 Occupational Health Department

The Occupational Health Service, in conjunction with managers, is responsible for promoting and helping to maintain a high standard of good health at work for all staff of the Trust. This encompasses both mental and physical health and well-being. The Occupational Health department is responsible for:

- Work Health Assessments and evaluating any implications for fitness;

- the provision of, or arrangement for, treatment of employees becoming ill or who are injured at work.

- the assessment of the needs of health surveillance programmes and provision of relevant health information on jobs or processes to protect employees health;

- advising management regarding the fitness of individuals and the suitability of working practices;

- the provision of advice on rehabilitation and help with resettlement into appropriate work;

- the provision of advice and care to employees after accidents at work and to provide quarterly report to the Health, Safety & Fire Committee to monitor risks to health from accidents;

- the investigation of outbreaks of acute ill-health affecting employees and implementing appropriate control measures and to liaise with Infection Control as appropriate;

- to liaise with others, e.g. Safety Consultants, Infection Control and the Health Safety & Fire Committee, to formulate policy and examine working practices;

- developing health promotion practices to help employees meet and address their health needs and assist employers' responsibilities;

- the implementation of relevant health care programmes, such as an immunisation service;

- the provision of a secondary counselling role and liaison with the Trust Counselling Service.

The Occupational Health Service is provided by the Royal Marsden NHS Trust under contract to Chelsea & Westminster Hospital NHS Trust. The contract is managed by the Chief People Officer and Director of Corporate Affairs.

3.16.2 Infection Control Team

The Infection Control Team is responsible for undertaking surveillance of infection for the prevention and management of outbreaks and report to the Trust's Infection Control Committee. It will provide education in all relevant aspects of infection control and prepare policies for and give advice on infection control issues.

The Infection Control Team will keep up to date with all new developments and procedures relating to infection control, disseminating this information to all appropriate sectors of the Trust.

In addition to this advisory and monitoring role, in the event of a major infection outbreak, the Consultant Microbiologist and Infection Control Nurses have executive authority, and all managers will ensure compliance with the procedures and advice provided.

3.16.3 Risk Managers

Risk Managers are part of the Clinical Governance Support Team and will work closely with nominated Risk Leads within Directorates and Departments to implement the Risk Management Strategy and policy for the Trust. In particular, the Risk Managers will:

- Support the risk management process to promote incident reporting

- Work with the Health & Safety Consultant, Occupational Health and others to provide a holistic risk management approach

- Forge links with all risk and governance activities

- Provide advice and support on clinical risk matters

3.16.4 Manual Handling Advisor

The Trust has appointed Manual Handling Advisors to advise on manual handling issues. The main duties and responsibilities are:

- To implement, audit, review and develop the Moving & Handling Policy;
- To assist managers undertake ergonomic workplace assessments;
- To advise the Trust on appropriate handling equipment to complement safe handling practice;
- To develop appropriate codes of practice for safe handling;
- To develop appropriate training programmes and deliver those programmes to Trust employees.

3.16.5 The Radiation Protection Advisor

The Chelsea and Westminster Hospital NHS Foundation Trust has appointed Radiation Protection Advisors to provide a Radiation Protection Advice service. The role is to provide advice on all matters relating to radiation protection and radiation safety. The role includes review of working practices, advice on environmental requirements and on monitoring; liaison with enforcement bodies and ensuring maintenance of records of all acquisitions and disposals of radioactive substances.

The duties and responsibilities are:

- to assist and consult with the Divisional Medical Directors and managers in drawing up local rules for radiation work, and to ensure that these are updated as necessary in order to be always relevant to the work performed;
- to assist the Trust to comply with relevant legislation and enforcing bodies, e.g. Environment Agency, Health & Safety Executive.
- to ensure that local rules are available to all relevant staff and are applied effectively;
- to instruct individual staff on specific equipment, procedures etc;
- to report to the appropriate manager all incidents, hazards, potential problems with the radiation work, and on any new training requirements;
- to ensure that monitored staff have access to the results of routine dose monitoring;
- to liaise as necessary with the radiation protection service and other safety specialists;
- to review staff doses and investigate radiation incidents;
- to provide radiation expertise with respect to the Ionising Radiations (Medical Exposure) Regulations;
- to attend safety and radiation protection committee meetings.

3.16.6 The Radiation Protection Supervisor

Radiation Protection Supervisors are appointed by managers for defined areas. The duties and responsibilities are defined in the Local Rules and include the following:

- to assist the Divisional Medical Directors, managers and the Radiation Protection Advisor in drawing up local rules for radiation work, and to ensure that these are updated as necessary in order to be always relevant to the work performed;
- to ensure that local rules are available to all relevant staff and are applied effectively;
- to instruct individual staff on specific equipment, procedures etc;
- to report to the appropriate manager all incidents, hazards, potential problems with the radiation work, and on any new training requirements;
- to ensure that monitored staff have access to the results of routine dose monitoring;
- to liaise as necessary with the radiation protection service and other safety specialists;
- in conjunction with the Divisional Medical Director or appropriate manager, to consult with the Radiation Protection Advisor on any proposals which will change existing radiation practices, or which will introduce new procedures.

3.16.7 Clinical Engineering Department

The Clinical Engineering Department is responsible for overseeing from a health and safety viewpoint, the selection and subsequent maintenance of medical equipment. In addition they receive, distribute and coordinate responses to Medicines & Healthcare Regulatory Agency (MHRA) Safety Alerts;

3.16.8 Estates and Facilities Directorate

The Estates and Facilities Directorate is responsible for:

- Ensuring that the estate plant and non-medical equipment is maintained in a safe condition by arranging regular maintenance and inspection schedules.
- Ensuring compliance and record keeping in line with Statutory Instruments, including Health Technical Memoranda, Health Building Notes, Approved Codes of Practice and other mandatory standards, as well as the Electricity at Work Regulations, Provision and Use of Work Equipment Regulations and lifting operations and Lifting Equipment Regulations.
- Ensuring that all contractors employed on Trust sites demonstrate compliance with the Health and Safety at Work Act and associated regulations and are aware of the Trust's Health and Safety Policies and Procedures.
- Ensuring that written records are kept of the communication of health and safety requirements to contractors.
- Ensuring that a "Permit to Work" system is operated where risks to an individual or to the organisation have been identified (e.g. hot work, entry into confined spaces and work involving medical gases);

- Responsible for nominating a competent CDM Co-ordinator for certain projects as required in the Construction (Design and Management) Regulations (CDM).

3.16.9 Local Security Management Specialist (LSMS)

The Trust LSMS is responsible for the overall management of the Security and for recommending strategies for security risk management across the Trust. This will include monitoring the effectiveness of security and crime prevention measures, identifying and participating in relevant security and personal safety training and awareness sessions and for advising all levels of staff on appropriate security and crime prevention measures.

3.16.10 Health & Safety Organisation Structure

Attached at Appendix 1 is a flowchart describing the organisation arrangements for health and safety management within the Trust.

4. Health & Safety Arrangements

4.1 Policies, Procedures and Codes of Practice

All Policies, procedures and codes of practice approved by the Trust Executive Quality Committee, Risk Management Committee, the Health, Safety & Fire Committee, the Radiation Safety Committee, the Sustainability Committee and Control of Infection Committee are accessible at locations throughout the Trust's premises. This information is also made available on the Trust intranet as each policy or procedure is reviewed.

Managers shall ensure that each member of staff is made aware of and understands those documents that apply to them.

4.2 Identifying Hazards, and Assessing, Controlling & Monitoring Risks

Each area of the Trust is inspected at regular intervals by the Safety Co-ordinator to identify hazards in the workplace. The hazards that cannot be immediately eliminated are subjected to risk assessment.

Assessments are carried out by the Safety Co-ordinator or other competent person. Assessments are recorded in a retrievable format and are produced in consultation with persons directly affected.

Risk assessments are reviewed by the Safety Consultants as part of a rolling programme of safety inspections. Reports are presented to the Safety Committee for consideration and follow up where required.

Safety audits are carried out on a 5-year programme. Executive summaries are presented to the Safety Committee for consideration and follow up where required. Follow up inspections are carried out to monitor progress in implementation of recommendations and reported back to the Safety Committee.

4.3 Accident, Incident and Hazard Reporting

All accidents, incidents, hazards, near misses and violent occurrences, which occur on Trust premises, are to be reported on the Trust accident/incident report forms.

Accident/incident report forms are available from Heads of Department/Safety Co-ordinators or the Safety Consultant. It is the responsibility of the Manager in whose area the accident occurred to ensure that an adequate report is made and followed up where appropriate. The Policy for Incident Reporting must be followed at all times.

Accidents/Incidents & serious untoward events involving clinical risk are reviewed under the auspices of the Trust's Clinical Governance arrangements.

The Safety Consultants review health & safety reports to determine the severity and the remedial actions taken to prevent the accident occurring again. Accidents that fall under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) are reported by the Safety Consultant on behalf of the Trust. Expectations of RIDDOR are set out in section 4.4 below.

4.4 The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) – Reporting Guidance

Accidents and diseases that arise out of or in connection with work must be reported to the Health & Safety Executive (HSE). The HSE has laid down criteria for these types of accidents etc and some of these are given below.

Staff or Visitor Major Injuries/Death
Managers must notify the Trust's Safety Office **IMMEDIATELY** during office hours and the Clinical Site Manager out hours if there is an accident connected with work **and**:

- A member of staff, or a self-employed person, e.g. contractors, working on our premises dies or suffers a major injury (including as a result of physical violence); **or**
- A member of the public dies **or**
- A member of the public (including patients) sustains a major injury.

Major injuries include:

- Fracture (except to fingers, thumbs or toes), amputation, dislocation (of shoulder, hip, knee or spine), loss of sight (temporary or permanent), chemical or hot metal burn to the eye, electric shock or any other injury leading to unconsciousness or requiring resuscitation, or any injury requiring admittance to hospital for more than 24 hours.

Accidents That Result in Inability to Work Over 7 Days

- Any accident or incident which leads to a member of staff being **unavailable for work for more than seven days.**

An over-7-day injury is one which is not "major" but results in the injured person being away from work OR unable to do their full range of their normal duties for more than seven days (including non-work days).

It is this category where it is important that managers inform the Safety Office within 48 hours when they become aware that a member of staff is going to be off work or has been for more than seven days. Examples of this may include injuries as a result of a slip or fall, manual handling, physical or verbal assault etc.

It is recognised that managers may not always know how long a staff member is going to be away immediately following an accident. However, the person must be asked if they were unable to perform normal duties for more than 7 days as soon as they return to work.

Diseases
Advice must be sought from Occupational Health as soon as possible if a member of staff becomes ill at work or as a result of work.
Reportable diseases include (non-exclusive list):

- Some skin diseases such as : occupational dermatitis.
- Occupational asthma or respiratory sensitisation.
- Infections such as: leptospirosis; hepatitis; tuberculosis; anthrax; legionellosis and tetanus.
- Other conditions such as: occupational cancer; certain musculoskeletal disorders including work related upper limb disorder (RSI); hand-arm vibration syndrome.

Dangerous Occurrences
Dangerous occurrences are specified events which may not result in a reportable injury, but have the potential to do significant harm.

Reportable dangerous occurrences include the following:

- The collapse, overturning or failure of load-bearing parts of lifts and lifting equipment e.g. hoist failure.
- The accidental release of a biological agent likely to cause severe human illness (a hazard group 3 or 4 pathogen) e.g. needlestick injury known to contain pathogen 3 or 4 material – Hep B, HIV.
- The accidental release of any substance which may damage health.
- The explosion, collapse or bursting of any closed vessel or associated pipework.
- An electrical short circuit or overload causing fire or explosion.
- An explosion or fire causing suspension of normal work for over 24 hours.

Should any of the above occur the Safety Office should be contacted **IMMEDIATELY** on extension 58656.

4.5 Training and Information

Training is an indispensable ingredient of an effective health and safety system and it is essential that all grades and disciplines of staff are trained to perform their job effectively and safely.

All managers will identify the health and safety training needs of their staff as part of the personal development planning process. All staff identified as Safety Coordinators, COSHH Assessors, Fire Marshalls and Safety Representatives will attend health and safety training specific to their needs.

General health and safety awareness will be included in the Trust Induction Programme, reinforced with more specific training as part of Department induction. Additional training will be provided when staff are exposed to new or increased risks because of a change in responsibilities or place of work. Refresher training will be provided as appropriate and in line with the Trust Policy for Statutory & Mandatory Training.

Managers will ensure the maintenance of training attendance records and that inadequate attendance is rectified.

4.6 First Aid

The Trust maintains suitable numbers of first aid personnel to deal with minor accidents and emergencies at the workplace. These personnel have sufficient training and qualifications in accordance with statutory requirements. Members of staff should familiarise themselves with who is their nearest first aider. Further information is contained in the Trust First Aid Policy.

4.7 Emergency Procedures

The Chief Executive will ensure that arrangements are in place for the development of robust plans to deal with all situations which may present serious and imminent danger to the health and safety of people. These include for example:

- Major incident and Internal Disaster Plans
- Fire Evacuation Plans
- Estates continuity plans for loss of utilities and services

- Bomb threat
- Radiation and chemical release

Managers will ensure that all staff within their area are familiar with these arrangements and have received suitable training. Managers will also ensure that other people who are in their area are informed of an emergency and of the arrangements in place to handle it.

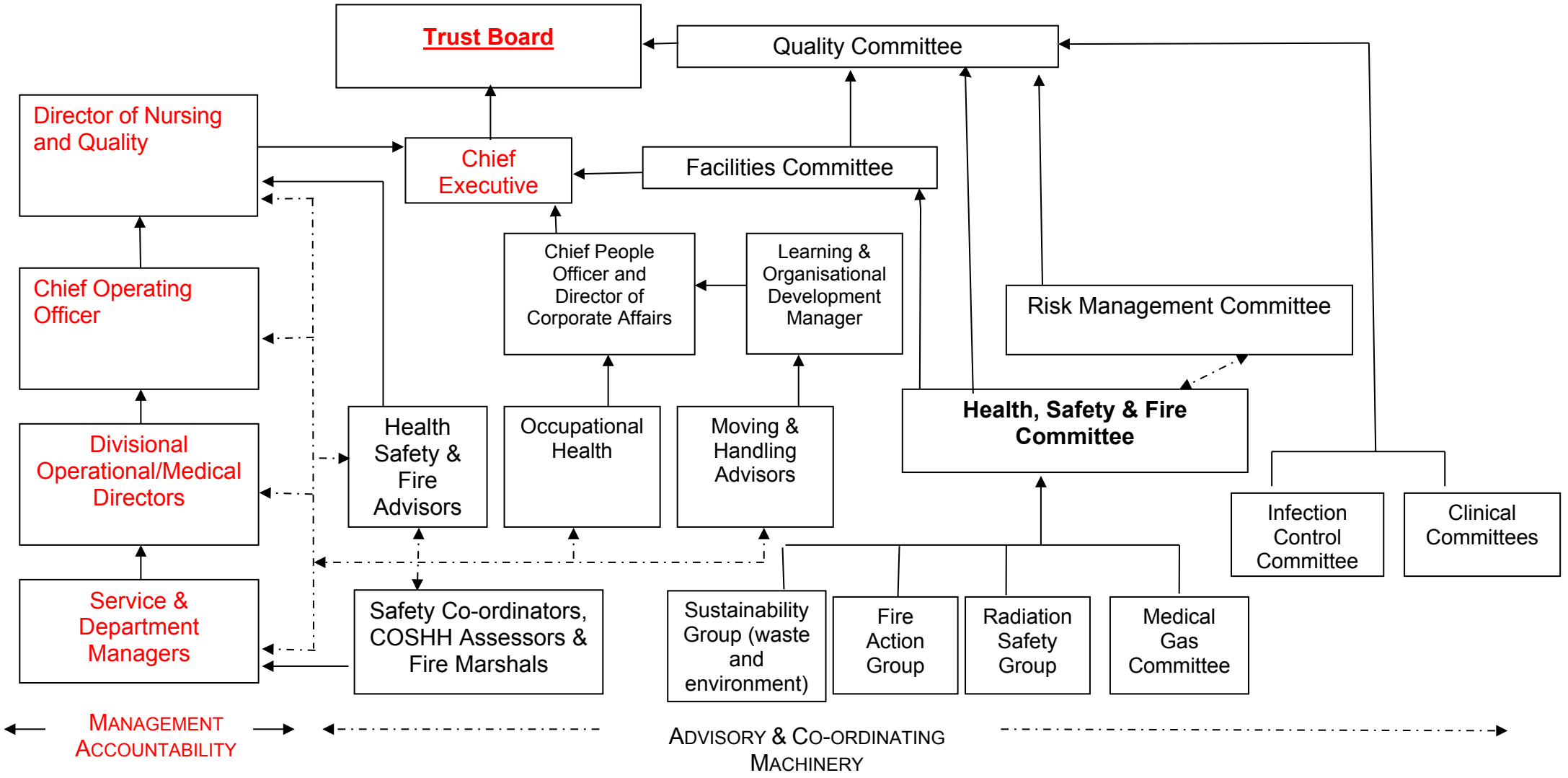
4.8 Monitoring This Policy

The Director of Nursing and Quality will ensure that the Health, Safety & Fire Committee review this policy on an annual basis. The effectiveness of the policy and arrangements are monitored by the Health, Safety & Fire Committee by reviewing the following:

- Mandatory Health & Safety training compliance
- Incidents graded yellow and above
- Relevant risk assessments graded orange and above
- Body fluid exposure trends and patterns
- Violence and aggression trends and patterns
- Waste non-conformity
- Health & safety performance feedback from Divisions.
- Trust Health & Safety Key Performance Indicators

Any changes made by the Trust Executive and/or Trust Board which have an impact on the arrangements set out in this policy will be brought to the attention of the Health, Safety & Fire Committee and amendments proposed to the policy, as necessary.

APPENDIX 1: SAFETY MANAGEMENT STRUCTURE



Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Finance Report – December 2014/3.1/Jan/15
Purpose of paper	To report the financial performance for the nine months ending 31st December 2014
Decision/action required/ recommendation	The Trust Board is asked to note the financial position for December 2014.
Summary of the key risks/issues from the paper	**The Trust financial performance can be summarised as:** - In December the Trust has reported a breakeven position, bringing the year to date position to a £0.2m deficit. - The year to date position is a £6.9m adverse variance against plan. - The Trust has set a revised year-end forecast of £2.2m against the plan of £7.1m, and monthly divisional control totals have been agreed to deliver the forecast. - December's position is £0.2m behind the control total of £0.2m for the month. **The key drivers behind the December I&E performance** - NHS Clinical income is adverse against the control total by £0.2m - Private patient income is adverse against the control total by £0.1m mainly attributed to lower than expected PMU deliveries - Pay costs were favourable against the control total following a reduction in usage of bank and agency **Cash and Capital** - The cash position is £13m which is lower than plan due to continued high levels of debt and impact of I&E performance - Capital spend for the year to date was £11m, which is £1.8m behind the revised capital forecast. **Year End forecast** - The year-end forecast remains a £2.2m surplus and the forecast COSR remains a 3 as planned.
Link to corporate objectives	Ensure Financial and Environmental Sustainability Deliver 'Fit for the Future' programme
Executive Sponsor	Rakesh Patel, Director of Finance

Finance Report for the period ending December 2014 (Month 9)

1. Introduction

1.1. This report provides the Board with a commentary on the financial performance for the nine months ending December 2014.

2. Decision/ Action required

2.1. The Trust Board is asked to note the financial position for December 2014.

3. Background

3.1. The Trust reported a breakeven position in December 2014. The year to date position is a deficit of £0.2m, which is an adverse variance of £6.9m against an original planned surplus of £6.7m. The year to date EBITDA is 7.2% against a planned EBITDA of 9.7%.

3.2. The Trust has set a revised year-end forecast of £2.2m against the plan of £7.1m. Monthly divisional control totals have been agreed to deliver the forecast. In order to achieve this, the Trust should have delivered a surplus of £0.2m in December and therefore is £0.2m behind trajectory.

3.3. The CIP achieved to date is 3.2% and the forecast is 3.3%.

3.4. Although the current year to date position is a deficit, the year-end forecast remains a surplus of between £2.2m and further actions and controls agreed by the Executive Team have been implemented to ensure delivery of this.

3.5. The primary reasons for the current month's performance are £0.2m behind the control total for NHS Clinical income and Private patient income under-performance of £0.1m.

4. Content

4.1. NHS and Local Authority Clinical Income

- The underlying NHS clinical income is £0.2m behind the control total in December. The primary factors behind the shortfall are:
    - £0.2m behind for Assisted Conception activity due to the closure of the unit over the Christmas period and an increase in income credits given to CCGs relating to planned procedures with thresholds contractual metric.
    - Outpatient income was also £0.2m behind the control total mainly due to a decrease in GUM activity in December.
    - Elective income was £0.1m ahead of the control total largely as a result of the continued increase in elective activity associated with the RTT recovery plan.
    - A&E income was £0.1m ahead of the control total due to an increase in A&E attendances, particularly in the first half of the month.

- For the year to date, clinical income is £3.3m ahead of plan. The year to date over-performance continues to be driven by high GUM activity at Dean Street Express (£2.8m), elective activity associated with referral-to-treatment targets (£1.1m) and high levels of A&E attendances (£1.0m), offset by an under-performance on non-elective specialised services (£0.5m) which are not under the block contract.

- The Trust has seen sustained higher levels of elective activity in 2014/15, primarily due to additional activity as part of the RTT recovery plan, however activity was lower in December than previous months, due to the lower number of working days. However, the average elective income per working day in December (£185k) was ahead of the control total for the month (£179k). It should be noted that the control totals for future months assumes increased elective income per day than the year to date position, which is a risk to the forecast.

- Non-elective admissions in 2014/15 have remained in line with activity in 2013/14; though December 2014 was c100 (~5%) spells higher than the previous year. Although the year to date activity is in line with the prior year, the income is behind plan due to the case-mix (particularly HIV, Burns and paediatric surgery).

- GUM outpatient activity has shown a steady increase in 2014/15 following the opening of Dean Street Express, with a year to date increase of 39% on last year's activity. There was a reduction in activity in December, as expected over the Christmas period.

4.2. **Other Income**

- In December, Private Patient income was £0.1m behind the control total. This was mainly attributed to lower than expected PMU deliveries of 60 against the forecast of 69. The average income per delivery was also below plan this month, in-part due to a reduced length of stay and subsequent amenity usage reductions.

- For other private activity, income is up 20% year to date compared to 2013/14 and expenditure levels have risen by 5% only, reflecting utilisation of spare capacity, the renegotiation of internal and external trading arrangements and improved controls.

4.3. **Expenditure**

- Pay expenditure overall reported a favourable variance against the control total in December by £0.1m, primarily due to a reduction in nursing bank and agency by 7,600 hours. Normalised pay spend in December was £0.3m lower than November and was the second lowest overall pay spend for the year to date.

- The reduction in bank and agency hours compared to November is primarily in the Burns Unit (due to lower activity in the month and a reduction in 1:1 specialling), Maternity (reduction in double running costs following the completion of the induction process for new starters) and some of the wards (following recruitment to substantive posts). This has been partly offset by nursing contracted staff, which has continued to

increase since October, due to the new substantive staff coming into post.

- Continued reliance on temporary staff is required to cover remaining vacancies in a number of areas including locums for Medicine, Surgery and HIV/GUM, nursing posts in some key wards and NICU, AHP vacancies in physiotherapy and radiology. There are also a number of escalation beds open, which are partly funded by winter pressures monies.

- Clinical supplies spend was in line with control total for December. This continues to remain in line with trend and is £3.3m behind plan year to date, which is partly explained by the increase in activity as part of the RTT backlog clearance and associated income.

- Non-clinical supplies were behind £0.4m, which was mainly related to the West Middlesex transaction and is offset against income. There was a release of £0.8m of unutilised provision in December.

4.4. **Year-end Forecast**

- The year-end forecast remains a £2.2m surplus (as was reported in November). Further risks have been identified within the Planned Care division of £0.3m, relating to non-elective activity in quarter 4.

4.5. **Continuity of Services Risk Rating (COSR)**

- The Trust's COSR rating forecast is a 3 compared to a planned COSR rating of 3, based on a forecast surplus of £2.2m.

4.6. **Loans**

- There was no drawdown against the loans from the Independent Trust Financing Facility (ITFF) but further draw down is planned for later in the financial year relating to the Emergency Department development.

4.7. **Capital**

- The Trust revised capital plan for 2014/15 is £24.7m. The year to date capital expenditure year is £11m against the Trust's revised capital plan of £13m, which is £1.8m (14%) behind plan.

- IT capital expenditure is £2.4m year to date behind plan due to slippage against planned expenditure on several projects e.g. EPR Replacement including Last Word (£0.9m), IT Strategy Implementation (£0.3m), Patient Relationship Management (£0.3m), and Electronic Document Management (£0.2m).

- Buildings capital expenditure is £0.7m year to date ahead of plan with the ED refurbishment (£0.2m) and Immunology Lab (£0.2m) and Medicinema progressing faster than the submitted Monitor plan. Immunology Lab is complete and operational and has been capitalised in Quarter 3. The final account of this project is not available at the time of writing this report.

- The medical and non-medical equipment are within the plan. The major expenditure in Imaging both for ED Redevelopment and Radiology Department will be incurred in Quarter 4.

4.8. **Cash Flow**

- The cash position at 31st December was £12.8m, against a plan of £22m. The principal causes are the level of debt which is yet to be recovered and the deficit position of £0.2m against a planned surplus of £6.7m.

- The top ten billed debtors outstanding are made up of £5.7m relating to NHS organisations and Department of Health, Foundation Trust debt amounting to £0.5m and Local Government debt amounting to £1.4m. The Trust has further increased efforts in collecting debt to improve the cash position, including employing a new member of staff on an interim basis to help on recovering the aged debt and daily review meetings between financial accounting and income teams to close off queries and ensure timely escalation of disputes.

5. Summary

5.1. The Trust reported:
- In month breakeven position against a control total of £0.2m – an adverse variance of £0.2m
- Year to date deficit of £0.2m against a planned surplus of £6.7m – an adverse variance of £6.9m

5.2. The year-end forecast position is a £2.2m surplus against a plan of £7.0m. The forecast COSR, on delivery of a £2.2m surplus, is a rating of 3.

Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Performance and Quality Report – December 2014/3.2/Jan/15
Purpose of paper	To report the Trust's performance for December 2014, highlight risk issues and identify key actions going forward.
Decision/action required/ recommendation	The Trust Board is asked to note the performance for December 2014.
Summary of the key risks/issues from the paper	The Trust continues to meet all key performance indicators for Monitor; with the exception of planned non-achievement of RTT 18 weeks admitted patient pathways in Q3. - All three RTT indicators were achieved in December, with the admitted standard met for the first time since March 2014. - A&E waiting times national target of 95% was achieved in December and Q3, with an improvement on November. - Patient Safety: There were 2 C Difficile cases in December, bringing the total to 6 for the year to date. There has been a reduction in the prevalence of pressure ulcers, with the challenging target achieved in December and for the quarter. - Clinical Effectiveness: There has been an improvement in the clinical effectiveness measures such as peripheral line and urinary catheter continuing care in December. Caesarean section rates increased in the month to 35.1% and there remains continued review & scrutiny on this issue. All processes and pathways remain in place to promote natural deliveries. - Patient experience: Response rates have improved for the Friends and Family Test in the month, though overall response rates remain below the Trust target. Work continues to improve turnaround times and address themes identified through complaints. - Access and Efficiency: Performance against the 4 hour waiting time indicator was 95.7% and there has been a reduction in the number of LAS handover breaches in the month. Choose and book slot issues remain high, with recruitment plans in place to address pressures in the community dermatology and ophthalmology services.
Link to corporate objectives	This paper reports progress on a number of key performance areas which support delivery of the Trust's overarching aims.
Executive Sponsor	Rob Hodgkiss, Chief Operating Officer

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Performance and Quality Report

Performance to 31st Dec 2014

At a Glance Performance – December

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Patient Safety Domain

- Hospital Associated VTE: 0
- Harm Free Score: 96.0%
- Cdiff Infections: 2
- Mortality SHMI: 79.0
- Never Events: 0
- Med. Related Safety Incidents: 7.3

Clinical Effectiveness Domain

- Time to Theatre Urgent Surgery: 95.6%
- 12hr consultant assessment: 78.04%
- Dementia Case Finding: 87.6%
- Emergency Re-admissions: 2.55%
- Caesarean Section Rate: 34.7%

Patient Experience Domain

- FFT Local Positive: 87.3%
- Hospital Cancellations: 9.6%
- FFT Response Rate: 24.8%
- Formal Complaints: 11.76%
- Staff FFT - To receive care: n/a
- Staff FFT - Place to Work: n/a

Access & Activity Domain

- A&E Waiting Times: 95.7%
- 18 weeks RTT Admitted: 91.5%
- Choose & Book Slot Issues: 7.7%
- EL & DC Activity: 3391
- DTOCs: 3.28%

Process Efficiency Domain

- Avg Wait New OP Appt: 5.7
- Theatre Conversion rate: 89.2%
- OP Letters sent <7 working days: 56.1%
- Theatre Active Time: 73.8%
- DSUM sent before Disch.: 64.9%

External Compliance Domain

- Monitor Compliance: 100%
- CQUIN Compliance: 98.2%

Work Force Domain

- Sickness Rate: 3.3%
- Turnover Rate: 19.4%
- Appraisal Completion: 71.5%
- Vacancy Rate: 11.4%
- Avg Days for Recruitment: 56 days

Finance Domain

- I&E Surplus: £-0.2m
- EBITDA: 7.2%
- CIP Identified: £10.3m
- COSRR: 3
- Cash: £12.8m

Trust Headlines – 2014

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Monitor Compliance – Dec 2014

Sub Domain	Trust Level Monthly Data @ 16/01/2015 XL				YTD XL
	MonthYear	Oct 2014	Nov 2014	Dec 2014	01/04/2014
Harm	Clostridium difficile infections (Target: < 0.67)	0	0	2	6
	MRSA Bacteraemia (Target: < 0)	0	0	0	0
Cancer	Cancer diagnosis to treatment waiting times - 31 Days (Target: > 96%)	100.0%	100.0%	N/A	99.6%
	Cancer diagnosis to treatment waiting times - Subsequent Surgery (Target: > 94%)	N/A	N/A	N/A	100.0%
	Cancer diagnosis to treatment waiting times - Subsequent Medicine (Target: > 98%)	100.0%	N/A	N/A	100.0%
	Cancer urgent referral GP to treatment waiting times (62 Days) (Target: > 85%)	95.7%	96.8%	N/A	93.2%
	Cancer urgent referral Consultant to treatment waiting times (62 Days) (Target: > 90%)	100.0%	N/A	N/A	95.0%
	Cancer urgent referral to first outpatient appointment waiting times (2WW) (Target: > 93%)	95.6%	95.1%	N/A	95.1%
RTT	18 week referral to treatment times Admitted Patients (Target: > 90%)	85.2%	83.9%	91.3%	84.2%
	18 week referral to treatment times Non Admitted Patients (Target: > 95%)	96.0%	95.7%	95.9%	96.2%
	18 week RTT incomplete pathways (Target: > 92%)	92.3%	92.8%	92.1%	92.1%
A&E	A&E waiting times (Target: > 98%)	95.9%	94.9%	95.7%	96.2%
LD	Self-certification against compliance with requirements regarding access to healthcare for pe...	Compliant	Compliant	Compliant	Compliant

*The Monitor MRSA de minimus target is 6 cases, however we measure against a stretch target of 0
*The Monitor A&E target is 95% under 4hr wait, however we measure against an internal stretch target of 98%

Performance Headlines

Improvements

- With the exception of agreed non-compliance of the 18 weeks RTT admitted indicators, the Trust has achieved all of the Monitor indicators for quarter 3
- A&E waiting times national target of 95% was achieved in December, with an improvement on November
- All 3 RTT indicators were achieved in December, with the admitted standard met for the first time since March 2014.
- There has been a reduction in the prevalence of pressure ulcers, with the challenging target achieved in December and for the quarter.

Challenges

- There were 2 clostridium difficile cases in December, however there were no further cases in the quarter.
- Caesarean section rates increased in the month to 35.1% and there remains continued review & scrutiny on this issue. All processes and pathways remain in place to promote natural deliveries.
- Choose and book slot issues remain high, with pressures in the community dermatology and ophthalmology services. Recruitment to a locum Ophthalmology consultant post is underway which will help reduce slot issues.
- Staff turnover continues to be high (at 19.37% in December)

Patient Safety

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Trust Level Monthly Data @ 19/01/2015 XL				YTD XL
	Month Year	Oct 2014	Nov 2014	Dec 2014	01/04/2014
Harm	Incidence of newly acquired category 3 and 4 pressure ulcers (Target: < 3.6)	4	1	2	15
	Safety Thermometer - Harm score (Target: > 90%)	96.5%	94.2%	96.0%	94.6%
	Safety Thermometer - Prevalence of Pressure Ulcers (Rate) (Target: < 3.45%)	2.2%	4.7%	2.8%	4.0%
HCAI	C Diff rate per 100k bed days pts aged >=2 (Target: < 14.7)	0.0	0.0	104.4	34.6
	Clostridium difficile infections (Target: < 0.67)	0	0	2	6
	Hand Hygiene Compliance (trajectory) (Target: > 90%)	97.4%	96.9%	97.2%	97.3%
	Methicillin Sensitive Staphylococcus Aureus Target < 4.1)	0	2	0	8
	E.Coli bloodstream infections Target < 12.4)	5	7	5	55
	MRSA Bacteraemia (Target: = 0)	0	0	0	0
	Screening all elective in-patients for MRSA (Target: > 95%)	90.1%	88.2%	95.3%	92.0%
	Screening Emergency patients for MRSA (Target: > 95%)	97.5%	98.1%	98.1%	97.7%
Incidents	Incident reporting rate per 100 admissions (Target: > 8.50)	7.42	7.36	6.10	7.48
	Inpatient falls per 1000 Inpatient bed-days (Target: < 3.00)	2.89	2.52	2.90	3.44
	Never Events (Target: = 0)	0	0	0	0
	Medication related safety incidents per 1000 admissions Target < 93.6)	7.1	7.4	7.3	7.3
	Rate of patient safety incidents per 100 admissions (Target: < 2.9)	7.06	6.80	5.51	7.09
	Rate of pt. safety incidents resulting in severe harm - death per 100 admissions (Target: = 0.00)	0.00	0.02	0.02	0.01
Mortality	Mortality (HSMR) (2 months in arrears) (trajectory) (Target: < 104)	N/A	N/A	N/A	74.4
	Mortality SHMI *TRUST ONLY* (Target: < 82)	79.0	79.0	79.0	79.9
	Number of In-hospital Deaths (Adults) (Target: ~ 0.6)	31	34	40	268
	Number of in-hospital deaths (Paeds) (Target: ~ 0)	0	0	0	0
	Number of in-hospital deaths (Neonatal) (Target: ~ 0.1)	3	1	1	27

Clostridium Difficile: In December there were 2 HAI Toxin and Gene positive C diffs, on different wards within the Trust. One came to no harm and a root cause analysis has yet to be completed on the second. That brings the number of cases to 6 for the year to date, with an objective to keep this below 8 for the year.

Incident reporting rate per 100:
The Trust has seen an increase in patient activity and a similar rate in reported serious incidents. There has also been a decrease in less serious incidents being reported by staff, which, in the context of increased activity and staffing pressures, explains the further reduction this month. In addition to this, an increasing number of staff are anecdotally discussing incidents, however not always formally reporting due to staffing pressures. These issues are being addressed via the Risk Management Committee; there are relevant risk assessments with associated action plans.

MRSA screening for Elective inpatients:
There has been a significant improvement in the screening of elective patients for MRSA in December, following a review of the process to ensure that all patients are rescreened where their MRSA screening has expired before their elective admission.

Safe Nursing and Midwifery Staffing

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Ward Name	Average fill rate registered nurses/midwives (%) day shift	Average fill rate care staff (%) day shift	Average fill rate registered nurses/midwives (%) night shift	Average fill rate care staff (%) night shift
Maternity	78.0%	66.1%	68.9%	58.8%
Annie Zunz	110.2%	158.1%	125.8%	161.3%
Apollo	77.4%	58.1%	78.3%	-
Jupiter	113.3%	76.5%	121.0%	100.0%
Mercury	98.9%	87.1%	94.2%	66.7%
Neptune	99.2%	100.0%	104.3%	87.1%
NICU	93.6%	-	97.1%	-
AAU	103.9%	104.9%	137.4%	100.0%
Nell Gwynne	108.5%	154.4%	112.9%	174.2%
David Erskine	101.5%	96.8%	100.0%	100.0%
Edgar Horne	123.3%	104.5%	174.9%	100.5%
Lord Wigram	97.8%	101.6%	104.8%	98.4%
Rainsford Mowlem	93.5%	94.1%	94.6%	109.7%
David Evans	100.4%	81.5%	130.6%	91.8%
Chelsea Wing	92.9%	91.1%	100.0%	83.9%
Burns Unit	100.0%	74.8%	97.9%	93.5%
Ron Johnson	102.1%	105.0%	103.3%	103.3%
ICU	100.7%	-	100.7%	-

National Quality Board Report – Hard Truths expectations:

The December fill rate data (table 1) is presented in the format as required by NHS England.

Definition – Fill rate:

The fill rate percentage is measured by collating the planned staffing levels for each ward for each day and night shift and comparing these to the actual staff on duty on a day by day basis. The fill rate percentages presented are aggregate data for the month and it is this information that is published by NHS England via NHS Choices each month.

Trusts are also required to publish this information on their own web sites, a recent survey has revealed that very few Trusts receive enquiries on the back of their fill rate data. The concern from the outset is that data aggregated at this level provides little or no meaning to the public.

Summary for December

The low fill rates for midwifery show a position that has remained unchanged for several months, midwifery staffing particularly around one to one care in labour is reported elsewhere in the Performance Report. The excessive fill rates for Annie Zunz relate to escalation capacity being open in this area, and AAU for trollies overnight. Edgar Horne have had a particularly difficult case mix of patients and have been reliant on RMN's and HCA specials during this month.

The areas requiring further review are Nell Gwynne and David Evans. David Evans have increased their night time staffing model to 3 registered nurses, it is not clear if this links to a business case or divisional decision as this is over and above their agreed establishment. The excess fill rates for Nell Gwynne relate to specials and RMNs.

Sub Domain	Trust Level Monthly Data @ 19/01/2015 — MonthYear	Oct 2014	Nov 2014	Dec 2014	YTD 01/04/2014
Admitted Care	Elective LoS - Long Stayers (Target: < 43)	44	63	55	504
	Elective Length of Stay (Target: < 3.7)	3.1	3.4	4.1	3.5
	Emergency Care Pathway - Discharges (Target: N/A)	199.7	189.7	185.9	1738.7
	Emergency Care Pathway - Length of Stay (Target: < 4.5)	4.64	4.70	5.35	4.61
	Emergency Re-Admissions within 30 days (adult and paed) (Target: < 2.8%)	2.80%	3.05%	2.55%	2.95%
	Non-Elective Long Stayers (Target: < 528)	483	422	441	3942
	Non-Elective Length of Stay (Target: < 3.9)	4.0	3.6	4.7	4.0
	VTE Assessment (Target: > 95%)	97.3%	96.8%	96.4%	96.6%
Best Practice	% Patients Nutritionally screened on admission *TRUST ONLY* (Target: > 90%)	79.7%	80.5%	81.5%	78.3%
	% Patients in longer than a week who are nutritionally re-screened *TRUST ONLY* (Target: > 90%)	73.7%	62.0%	74.4%	67.6%
	12 Hour consultant assessment - AAU Admissions (Target: > 90%)	76.1%	75.6%	80.3%	71.3%
	Central line continuing care—compliance with Care bundles (Target: > 90%)	100.0%	100.0%	100.0%	100.0%
	Peripheral line continuing care—compliance with Care bundles (Target: > 90%)	96.4%	77.8%	90.0%	87.9%
	Urinary catheters continuing care—compliance with Care bundles (Target: > 90%)	92.3%	88.9%	90.0%	95.8%
	Fractured Neck of Femur - Time to Theatre < 36 hrs for Medically Fit Patients (Target: = 100%)	100.0%	85.7%	84.6%	87.7%
	Safeguarding adults - Training Rates (Target: >)	tba	tba	tba	tba
	Safeguarding children - Training rates (Target: >)	tba	tba	tba	tba
	Stroke: Time spent on a stroke unit *TRUST ONLY* (Target: > 80%)	100.0%	100.0%	100.0%	100.0%
Best Practice	Dementia Screening Case Finding (Target: > 90%)	94.1%	96.7%	87.6%	93.2%
	Appropriate referral Dementia specialist diagnosis *TRUST ONLY* (Target: > 90%)	100.0%	100.0%	N/A	100.0%
	Dementia Screening Diagnostic Assessment (Target: > 90%)	100.0%	100.0%	100.0%	100.0%
Theatres	Procedures carried out as day cases (basket of 25 procedures) (Target: > 85%)	82.7%	84.4%	84.3%	81.6%
	Theatre Active Time - % Total of Staffed Time (Target: > 70%)	72.5%	75.9%	73.8%	73.6%
	Time to theatre for urgent surgery (NCEPOD recommendations) (Target: > 95%)	96.9%	94.8%	95.6%	94.6%

Procedures carried out as Day cases:
The Trust has seen an increase month on month on patients who have had their procedures completed as day case. However there is further potential for improvement for laparoscopic cholesysteomies. One of the General Surgeons will be leading on increasing lap chole day case lists through main theatres, which should result in an improvement in the number of patients treated in a day case setting for this procedure.

Elective LOS:
The number of elective patients in the Trust this month requiring after hospital care has significantly increased with a large number of elective patients requiring Medihome support, pushing the average Length of Stay up across the Trust.

A large number of complex elective procedures were performed in December, reflecting the continuing reduction in RTT backlog. This is demonstrated by the number of discharges from the High Dependency Unit

Non-Elective LOS:
Non elective Length of stay has increased in month and reflects the impact of the cold weather on the acuity of patients being admitted through A&E.

The expansion of Ambulatory Care is also preventing the admissions of less complex patients who would previously have be admitted for a short length of stay, and this has impacted on the average LOS.

Nutritional Screening on Admission:
Rescreening performance improved by 12% in December, following increased focus on 3 wards which are failing to meet the target. From 16th Jan there has been an introduction of weekly senior nurse presence to monitor the nutritional screening. Wards that are underperforming are monitored weekly and ward sisters notified of performance. Ward sisters have been trained to access live nutritional screening information.

12 hour consultant Assessment:
The 12 hour consultant assessment target is reported as non compliant, but manual audits have demonstrated that much of the issue lies with electronically capturing the time when patients are reviewed and that over 90% of patients are assessed within the timescale. There is therefore not concern regarding the quality of patient care and review. Further work continue to promote the electronic data capture further, particularly in AAU and the Emergency Observation Unit.

Clinical Effectiveness – Maternity

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

	Indicator	Measure	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD Total
Activity in Month	NHS Deliveries		416	417	405	422	412	433	462	464	427	432	3,874
	Private Deliveries			62	76	71	73	63	70	71	53	60	599
	Births	Birth Centre (excludes transfers)	No. of pts	83	67	79	65	65	65	59	64	48	595
		Home births	% NHS Dels	1.2%	1.2%	1.2%	0.7%	0.5%	0.9%	0.6%	0.2%	1.6%	
	Norm. Vaginal Deliveries	SVD	No. of pts	222	212	219	215	213	230	205	227	194	1,937
		Maintain normal SVD rate	52%	53.2%	52.3%	51.9%	52.2%	49.2%	49.8%	44.2%	53.2%	44.9%	
	C- Section	Total C/S rate overall	<27%	29.3%	32.3%	28.4%	28.9%	31.6%	30.1%	33.2%	27.9%	35.0%	
		Emergency C Sections	No. of pts	59	66	66	64	85	77	69	58	77	621
			<12%	14.1%	16.3%	15.6%	15.5%	19.6%	16.7%	14.9%	13.6%	17.8%	
		Elective C Sections	No. of pts	63	65	54	55	52	62	85	61	74	571
			<15%	15.1%	16.0%	12.8%	13.3%	12.0%	13.4%	18.3%	14.3%	17.1%	
	Assisted Deliveries	Ventouse, Forceps Kiwi	No. of pts	73	62	83	78	83	93	105	81	87	745
			10-15% (SD)	17.5%	15.3%	19.7%	18.9%	19.2%	20.1%	22.6%	19.0%	20.1%	
	Total CS Rate Based on Coded Spells		<27%	29.0%	32.5%	29.2%	29.2%	31.9%	31.2%	33.4%	28.0%	35.1%	
Clinical Indicators	PP Heamorrage	Blood loss >2000mls	<10	11	3	5	11	7	8	9	4	6	64
	Perineum	3rd/4th degree tears	<5%	7	10	9	6	8	8	18	12	13	91
				2.4%	3.6%	3.0%	2.0%	2.7%	2.5%	5.8%	3.9%	4.6%	
	Stillbirths	Number of Stillbirths		3	2	4	1	4	3	3	2	1	23
	Readmissions	Neonatal < 28 days of Birth (feeding)		4	5	2	7	7	2	3	8	1	39
		Of which were born at C&W		2	5	4	7	6	2	3	6	1	36
PbR	Pathways	Antenatal Bookings completed	509	463	539	492	524	476	471	498	495	430	4,388
		12+6 KPI	95%	92.9%	91.8%	95.8%	97.3%	95.8%	96.8%	95.2%	96.4%	95.4%	
		Postnatal discharges	221	222	214	238	228	249	223	235	254	N/A	1,863
Risk	Maternal Morbidity	Maternal Death		0	0	0	0	0	0	0	1	0	1
		ITU Admissions in Obstetrics	2 mths < 6	1	1	0	1	1	0	1	1	1	7
KPI	Trust Level Indicators	NBBS - offered and discussed	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
		Maternity Unit Closures	LSA Db	0	0	0	0	0	1	0	0	0	1
		1:1 care	100%	93.5%	93.2%	96.5%	93.6%	93.4%	93.0%	97.9%	98.4%	94.4%	
		Breastfeeding initiation rate	90%	89.9%	91.9%	93.4%	89.8%	88.5%	89.8%	88.8%	89.7%	90.3%	
		Women smoking at time of delivery	<10%	1.2%	0.7%	0.9%	1.5%	1.4%	1.7%	0.9%	2.1%	1.6%	
		Midwife to birth ratio (per WTE)	1:30	1:33	1:32	1:31	1:33	1:32	1:36	1:37	1:30	1:34	

NHS Deliveries
In month and YTD activity above plan.

C-Section Rate
The caesarean section rate increased to 35.1% in December. A focused piece of work led by one of the consultants shows that the December CS rate is within normal band width and not a statistical outlier. However, there remains continued review & scrutiny on this issue. All processes and pathways remain in place to promote natural deliveries.

3rd degree tears
Maternity governance team is monitoring the number of 3rd degree tears on an ongoing basis and reviewing the clinical notes for each case.

Maternity Pathways
Continued achievement of >95% for 12+6 antenatal bookings. Completed postnatal pathways continue to be above plan. Ongoing monitoring continues to evaluate any impact relating to Ealing Hospital and prospective management of capacity.

Breastfeeding Initiation
There has been an improvement in December, with the target achieved in the month. The infant feeding team are actively auditing. Training needs have been identified in recording feeding status correctly on Maternity system and will be addressed.

Midwife to birth ratio
There have been 20 new midwifery starters and 1-1 care in labour remains above 90%.

Sub Domain	Trust Level Monthly Data @ 19/01/2015 XL				YTD XL
	MonthYear	Oct 2014	Nov 2014	Dec 2014	01/04/2014
Complaints	Breach of Same Sex Accommodation *TRUST ONLY* (Target: = 0)	0	0	0	0
	Complaints (Type 1 and 2) - Communication (Target: < 13)	12	18	16	182
	Complaints (Type 1 and 2) - Discharge (Target: < 2)	0	3	1	17
	Complaints (Type 1 and 2) - Attitude / Behaviour (Target: < 16)	23	26	19	157
	Complaints Re-opened (Target: < 5%)	0.00%	3.57%	N/A	7.25%
	Complaints upheld by the Ombudsman *TRUST ONLY* (Target: = 0)	0	1	0	4
	Formal complaints responded in 25 working days (Target: = 100%)	79.17%	53.57%	N/A	64.25%
	Total Formal Complaints	24	28	17	207
Friends & Family	Friends & Family Test - A&E response rate (Target: > 20%)	23.6%	22.8%	22.0%	21.3%
	Friends & Family Test - Inpatients response rate (Target: > 30%)	33.1%	27.3%	27.6%	30.4%
	Friends & Family Test - Local +ve score (Trust) (Target: > 90%)	91.5%	86.0%	87.3%	89.7%
	Friends & Family Test - Net promoter score (Target: > 62)	69.0	55.4	59.6	61.0
	Friends & Family Test - Total response rate (Target: > 30%)	28.2%	23.5%	24.8%	24.3%

Friends and Family:

December figures have risen slightly from November, but still remain below Trust level target. Both A&E and Inpatients are individually achieving CQUIN response rates for Q3 - A&E >15% and Inpatients >25%, but inpatients are below Trust level targets, as is our overall response rate.

To improve response rates the survey suppliers have increased agent calls this month. Paediatric areas will be commencing surveys from March, outpatient & day cases have commenced surveys in January.

Complaints:

The total number of formal complaints reduced from 28 to 17 in December.

7 formal complaints regarding attitude and behaviour, were logged in December compared with 8 in November, there isn't any discernible pattern or trend in regards to location where these complaints are coming from, just over half are relating to nursing staff. However, it is as expected that the staffing group with the majority of contact to patients would be the source of the majority of complaints.

There were 4 complaints related to nursing staff, all with different issues but 3 were related in theme, that being not enough attention given to patient.

There were 4 formal complaints relating to communication, down from 10 in November, there were no particular trends in regards to location or any connecting theme to suggest there is any inherent problem.

Access and Efficiency (1)

Sub Domain	Trust Level Monthly Data @ 19/01/2015 XL — MonthYear	Oct 2014	Nov 2014	Dec 2014	YTD XL 01/04/2014
A&E	A&E Time to Treatment (Target: < 60)	01:08	01:15	01:09	01:08
	A&E waiting times (Target: > 98%)	95.9%	94.9%	95.7%	96.2%
	A&E: Unplanned Re-attendances (Target: < 5%)	6.18%	6.87%	6.92%	6.70%
	LAS Patient Handover Times - 30 mins (KPI2) *TRUST ONLY* (Target: < 0)	80	83	70	678
	LAS arrival to handover more than 60mins (KPI 3) *TRUST ONLY* (Target: < 0)	4	5	0	18
Cancer	Cancer Consultant Upgrade (Target: > 85%)	100.0%	100.0%	N/A	95.8%
	Cancer diagnosis to treatment waiting times - 31 Days (Target: > 96%)	100.0%	N/A	N/A	99.6%
	Cancer diagnosis to treatment waiting times - Subsequent Medicine (Target: > 98%)	100.0%	N/A	N/A	99.6%
	Cancer diagnosis to treatment waiting times - Subsequent Surgery (Target: > 94%)	N/A	N/A	N/A	100.0%
	Cancer urgent referral Consultant to treatment waiting times (62 Days) (Target: > 90%)	100.0%	100.0%	N/A	95.8%
	Cancer urgent referral GP to treatment waiting times (62 Days) (Target: > 85%)	95.7%	100.0%	N/A	93.5%
	Cancer urgent referral to first outpatient appointment waiting times (2WW) (Target: > 93%)	95.59%	95.30%	N/A	95.11%
OP	Average Wait – Referral to First Attendance (Weeks) (Target: < 6 weeks)	6.3	6.2	5.7	5.9
	Choose and Book slot issue % *TRUST ONLY* (Target: < 2.0%)	8.9%	9.0%	7.7%	6.6%
	Number of patients waiting longer than six weeks for a diagnostic test (Target: = 0)	0	0	0	0
	Rapid access chest pain clinic waiting times (Target: > 98%)	100.0%	100.0%	100.0%	100.0%
RTT	18 week referral to treatment times Admitted Patients (Target: > 90%)	85.1%	84.1%	91.5%	84.3%
	18 week referral to treatment times Non Admitted Patients (Target: > 95%)	96.0%	95.7%	95.9%	96.2%
	18 week RTT incomplete pathways (Target: > 92%)	92.3%	92.8%	92.1%	92.1%
	RTT Incomplete 52 Wk Patients @ Month End (Target: = 0)	0	0	0	1
IP	Average Wait – Decision to admit to Admission (Weeks) (Target: < 6 weeks)	8.9	8.0	6.9	8.7

Choose and Book slot issues: The choose and book slot issues have reduced as more capacity is made available through the start of the calendar year. There are still pressures with the community dermatology service and also within ophthalmology. These two specialties combined contribute over 80% of the slot issues. Recruitment to a locum consultant post within Ophthalmology is underway which will help reduce slot issues when in post.

A&E Performance: waiting times: Performance against the 4 hour waiting time indicator meets the national 95% target for this month, with C&W being one of the best performing Trusts in the country. The performance for Quarter 3 was 95.4% (Q1 was 97.3% and Q2 was 95.9%). Review of the attendances shows an increase in major attendances compared with last year, with UCC and paediatric A&E remaining relatively consistent. For October-December 2014, the Trust had a total of 30,136 attendances and 1,358 breaches, compared with 28,550 attendances and 542 breaches the previous year.

Detailed breach analyses continue to be undertaken. Winter pressure arrangements have been in place since October and support the Emergency Department until the end of March 2015.

LAS Handovers: There have been 70 breaches in December for the 30 minute handovers, which is a decrease on previous months and are symptomatic of surges to the department. No 60 mins breaches are reported for December.

Average wait – Decision to admit to admission: Capacity and demand modelling has been completed for each speciality, which demonstrates that in some specialities, there are long waits to a new appointment. This results in a longer waiting time to decision to admit. Work is being undertaken with T&O to ensure that patients are being seen by the right clinician, at the right point of their pathway. This means that a number of patients are being redirected to MSK services in their local areas, which will mean that they are seen much more quickly (average wait time 4 weeks) and will have the right intervention. This will also help reduce the wait for a new appointment in trauma and orthopaedics.

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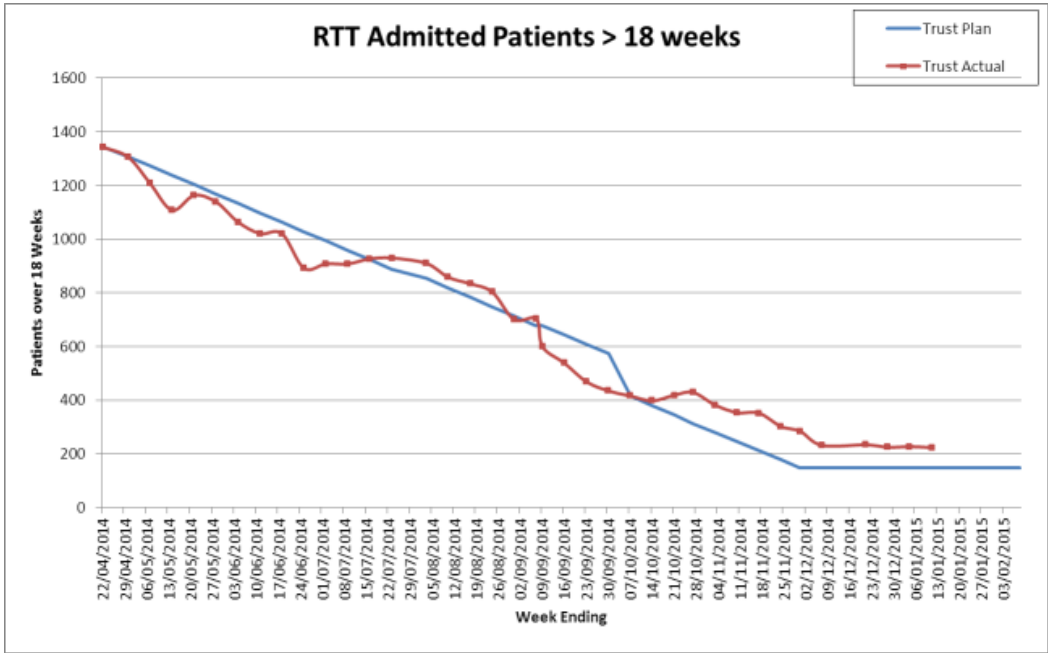
Access and Efficiency Deep Dive - RTT



RTT Admitted patients - December

Treatment Function	% Perf (Target 90%)
Total	**91.51%**
Dermatology	100.00%
Gastroenterology	100.00%
General Surgery	95.19%
Gynaecology	100.00%
Ophthalmology	**81.82%**
Plastic Surgery	90.96%
Trauma & Orthopaedics	**87.50%**
Urology	94.83%
Other	90.18%

In April 2014 the Board agreed, with Monitor and with CCG Commissioners support, that C&W would undertake an accelerated RTT admitted backlog clearance programme in order to treat long waiting patients as quickly as possible. This was planned to result in the Trust RTT performance against the Admitted standard being non-compliant during the first 3 quarters of 2014/15.

In terms of the national context, RTT performance has been under the spotlight since February 2014, when the admitted standard was not achieved nationally, while Trusts work to reduce long waiting lists. The Trust has received £1.4m from NHS England to undertake additional admitted and non-admitted work throughout Q2 and Q3, including funding for an additional 500 inpatient cases.

The Trust was compliant with all 3 RTT indicators in December, for the first time in 2014/15. The Trust is planning to continue to achieve all indicators in quarter 4.

Admitted Position

The number of long waiting patients has significantly reduced from c1,400 in April to c220 at the end of December by putting on additional capacity, improving utilisation of theatre sessions and addressing specific resourcing issues in paediatric dentistry. The Trust achieved the overall Trust-wide position in December (91.5% against a target of 90%) and only 2 specialties did not achieve the target – Ophthalmology and Trauma & Orthopaedics.

The Trust will continue ongoing focus on a daily basis to ensure the admitted position is continued to be achieved in Q4 and ensure that the position is sustainable going into 2015/16, to ensure that patients are treated as quickly as possible.

National RTT Validation

The Trust has engaged with the National RTT Validation exercise commissioned and a team of validators are working with the Trust from mid January, with the intention to undertake a full validation of waiting list pathways over 6 weeks.

Access and Efficiency (2)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Trust Level Monthly Data @ 19/01/2015	Oct 2014	Nov 2014	Dec 2014	YTD 01/04/2014
	MonthYear				
Admitted	Delayed transfers - Patients affected *TRUST ONLY* (Target: < 2.00%)	2.31%	0.86%	3.28%	1.96%
	Delayed transfers of care days lost (Target: < 644)	264	280	426	2591
DQ	Coding Levels complete - 7 days from month end (Target: > 95%)	98.8%	98.8%	98.7%	98.5%
	Total NHS Number compliance (Target: > 98%)	96.6%	96.8%	96.8%	96.8%
GP Real Time	Discharge Summaries Sent < 24 hours (Target: > 70%)	78.8%	79.4%	76.2%	79.5%
	Discharge Summaries Sent Before Discharge (Target: > 80%)	63.4%	65.1%	64.9%	64.5%
	GP notification of an A&E-UCC attendance < 24 hours (Target: > 70%)	99.96%	99.96%	99.92%	99.75%
	GP notification of an emergency admission within 24 hours of admission (Target: >)	100.00%	99.75%	99.83%	99.87%
	GP Notification of discharge planning within 48 hours for patients >75 (Target: > 70%)	69.46%	67.77%	63.85%	67.42%
Outpatients	OP Letters Sent < 7 Working Days (Target: > 70%)	60.7%	65.3%	56.1%	72.7%
	Average PICs per patient (Target: < 0.64)	0.11	0.11	0.10	0.17
	DNA Rate (Target: <11.1%)	10.3%	10.9%	10.4%	10.9%
	First to Follow-up ratio (Target: < 1.5)	1.65	1.62	1.66	1.69
	Hospital cancellations \ reschedules of outpatient appointments % of total attendances (Target: < 8.00%)	9.4%	9.5%	9.6%	111.7%
	Hospital cancellations made with less than 6 Weeks Notice (Target: < 3%)	4.8%	4.6%	4.2%	4.4%
	Patient cancellations \ reschedules of outpatient appointments % of total attendances (Target: < 8%)	11.6%	11.3%	10.5%	17.9%
Theatres	No urgent op cancelled twice (Target: = 0)	0	0	0	0
	On the day cancellations not rebooked within 28 days (Target: = 0)	0	1	2	3
	On the day cancelled operations (non clinical) % total elective admissions (Target: < 0.80%)	0.34%	0.40%	0.31%	0.30%
	Theatre booking conversion rate (Target: > 80%)	88.7%	88.4%	89.2%	88.0%

NHS Number Compliance: New staff members to the Trust are being issued smartcards and trained in looking up missing NHS numbers on the spine. Reports have been sent to the areas with worst performance to concentrate effort and weekly updates will be circulated to reception teams to ensure these details are confirmed at check in.

Discharge Summaries sent in real time – See CQUIN (page 13)

OP Letters sent <7 working days: Outpatient letter performance deterioration over the last few months has been an unintended consequence of the Trust priority focus given to clearing the RTT backlog. The further deterioration in December (4,657 of 17,808 outpatient letters not sent within 7 days) was compounded by annual leave over the festive period. Recovering the performance is now a priority focus for services particularly: Plastic Surgery; General Surgery; Dermatology; Gastroenterology; Gynaecology and Trauma & Orthopaedics where OP letter turnaround is worst.

First to Follow-up ratio: The YTD 14/15 average ratio for the Trust is 1.68 (1.77 for 2013/14). Through the clinical follow-up audit undertaken in Q3 a number of opportunities were highlighted to convert current face to face attendances to virtual attendances. This provides an opportunity to reduce this ratio and reduce the need for patients to attend the hospital. It is forecasted that by March 2015 there will be a 65% increase in virtual appointments offered to patients. A critical success factor will be the uptake by patients of this change in case management.

On the day Cancellations not rebooked within 28 Days: One patient had requested a procedure under Local Anaesthetic, however when they arrived on the day, the surgeon felt it was more appropriate to do the procedure under general anaesthetic and as the patient had eaten, the surgery was postponed. The patient wasn't available for pre-assessment to undertake a general anaesthetic until 15th Jan which meant the procedure could not be rebooked until after that date (for patient safety). The second patient was a Pain Management patient that was cancelled on the day on the 2nd December as there was no post op bed for the patient. This patient was on a monthly list which requires 2 consultants and unfortunately due to leave, consultant availability and capacity the patient breached and now has a date for the 3rd February.

Patient cancellations \ reschedules of outpatient appointments % of total attendances: A deep dive into the clinical specialities identified as having the higher rates of hospital cancellations has shown that one of the elements contributing to this has been the opening of clinics at short notice and moving patients already with an outpatient date in the future to these new clinics. Whilst this reduces the wait time for patients it is also an inefficient way to manage patients. There has been a significant drive across the entire Trust to drive improvement, but targeted on those specialities to ensure outpatient clinics are opened with a minimum of 6 weeks. This negates the need to open additional clinics at short notice and move patients.

CQUIN – Q2 Achievement (CCGs)

Type of CQUIN	Indicator name	Weighting of schemes	Q1 Performance	Q2 Performance
National	1) Friends and Family Test	5.00%	100.00%	100.00%
National	2) Use of the Safety Thermometer	5.00%	100.00%	100.00%
National	3) Diagnosis of Dementia	10.00%	100.00%	100.00%
CCG	4) Shared patient records and real time information systems	12.00%	100.00%	71.43%
CCG	5) Improving the Emergency care pathway	8.00%	100.00%	100.00%
CCG	6) Improving the planned care pathway	18.00%	100.00%	100.00%
CCG	7) Seven day services	18.00%	100.00%	100.00%
CCG	8) GP Direct Accesss	24.00%	100.00%	100.00%
		100.00%	100.00%	98.2%

CCGs signed off the Trust's Q1 and Q2 CQUIN performance at 100% for Q1 and 98.2% at Q2. The Trust is awaiting final confirmation from NHS England for the agreed % achievement for specialised services CQUIN schemes, but the Trust's assessment is 100% achievement for all indicators.

The only indicator that was not achieved in Q2 was the Diagnostic Cloud CQUIN, which related to the implementation of a standardised method of requesting, reporting and order management of diagnostic services. This was originally expected to be linked with Imperial Healthcare's solution, but this has not been feasible and additional funding is required to implement a standalone system for the Trust. Additional funding of £0.5m has been sought from CCGs to implement the system and the Trust is expecting confirmation regarding funding by the end of January.

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Domain	Type	Indicator Detail	Q1 Total	Q2 Total	Oct-14	Nov-14	Dec-14	Q3 Total	YTD
FFT	National	Friends & Family Test - Inpatients response rate (Target: >25.0%)	33.30%	30.40%	33.10%	27.30%	27.60%	30.20%	30.70%
		Friends & Family Test - A&E response rate (Target: >15.0%)	17.40%	23.30%	23.60%	22.80%	22.00%	23.20%	21.20%
		Friends & Family Test - Staff FFT	-	-	-	-	-	-	-
Safety Thermometer	National	Safety Thermometer Data Collection (Target: =100%)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
		Safety Thermometer - Prevalence of Pressure Ulcers (Rate) (Target: <3.45%)	4.00%	4.80%	2.20%	4.70%	2.80%	3.20%	4.00%
Dementia	National	Dementia Screening - Case Finding (Target: >90%)	97.20%	91.70%	92.50%	95.20%	87.30%	92.80%	93.20%
		Dementia Screening - Assessment (Target: >90%)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
		Dementia Screening - Appropriate Referral (Target: >90%)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
GP Communication in Real Time	Local	DSUMS Before Discharge 80% Target by Q4	63.80%	65.20%	63.40%	65.10%	65.00%	64.50%	64.50%
		GP Notification Of Emergency Admission withing 24 hours	99.86%	99.88%	100.00%	99.75%	99.83%	99.86%	99.82%
		GP Notification of A&E & UCC Attendance	99.30%	99.95%	99.96%	99.96%	99.92%	99.95%	99.79%

The Trust achieved the national CQUIN schemes of Friends and Family Test, Safety Thermometer data collection and Dementia Screening in December and is on track to achieve these for Q3 and Q4.

There remains a risk regarding the challenging target to reduce the prevalence of pressure ulcers to <3.45% in 2014/15, however the Q3 position has been achieved, with a rate of 3.2% for the quarter.

The other key CQUIN scheme at risk is the local scheme to send 80% discharge summaries to GPs in real time (within 1 hour of discharge) by quarter 4. The Trust sent 65% of discharge summaries in real time in December, and the performance has been similar throughout 2014/15. Although the Q1 and Q2 targets were met there was no improvement trajectory as no changes were required to meet the targets. Focus has been targeted at underperforming wards to increase the turnaround times to send out discharge summaries and to share best practice from the highest performing wards and departments. An action plan has been developed, which includes some changes to the PAS system to remind users to complete discharge summaries in real time, changing behaviour on wards and identifying champions and weekly monitoring through Trust meetings. Key specialties have been contacted and trajectories set to meet the Q4 target

Mandatory Training

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Division	Total	Corporate Division	Emergency & Integrated Care Division	Planned Care Division	Women's, Children's and Sexual Health Division
Fire	**62%**	73%	58%	65%	57%
Moving & Handling	**74%**	73%	71%	73%	76%
Safeguarding Adults Level 1	**100%**	100%	100%	100%	100%
Slips Trips and Falls	**84%**	86%	83%	87%	81%
Harassment & Bullying	**85%**	79%	90%	88%	81%
Information Governance	**47%**	47%	48%	49%	45%
Hand Hygiene	**76%**	78%	74%	76%	75%
Health & Safety	**84%**	87%	79%	87%	83%
Child Protection Level 1	**100%**	100%	100%	100%	100%
Innoculation Incident	**85%**	80%	85%	91%	82%
Basic Life Support	**72%**	81%	74%	70%	73%
Health Record Keeping	**84%**	83%	85%	84%	83%
Medicines Management	**90%**	90%	94%	92%	88%
VTE	**87%**	81%	85%	85%	91%
Blood	**81%**	79%	83%	81%	81%
Safeguarding Children Level 2	**80%**	86%	83%	81%	74%
Safeguarding Children Level 3	**70%**	67%	86%	68%	68%
Corporate Induction	**85%**	80%	85%	91%	82%
Local Induction	*Reporting of local induction is under review*				
Mandatory Training Compliance %	**77%**	77%	78%	79%	76%

Mandatory training figures in Dec 2014 were 77% which is 9.28% below target for the month. The ambitious target of reaching 95% compliance by the close of 2014/15 is highly aspirational and will require a review of our policy and processes in relation to mandatory training. Health & Safety training stands at 76% (compliance rate of staff trained within the two year refresher period across all staff groups)

Average (Statutory mandatory training) across LATTIN Trusts = 75% (latest data available)

Workforce

HR Metric		Monthly Target	Dec 14	~2013/14 Out-turn	2014/15 Annual Target	Average 12 month Rolling YTD
Turnover rate***		14.02%	19.37%	14.83%	13.50%	16.78%
Vacancies	Total	8.41%	11.42%	8.60%	8%	9.67%
	Active	3.25%	4.61%	3.02%	3.25%	3.61%
Time to Recruit	Authorisation to pre-employment checks completed	<55 days	56 days	-	<55 days	**52.25 days
Sickness rate		3.00%	3.31%	2.92%	3.00%	2.82%
Agency % of WTE		3.15%	3.40%	3.82%	3.15%	3.40%
Appraisals	Non-Med	80.18%	63%	85%	85%	83.47%
	Medical	81.18%	80.0%	70%	85%	73.2%
Mandatory training*		86.28%	77%	77%	95%	78.17%

Vacancies: The total Trust vacancy rate for Dec 2014 was 11.42%, which is an increase of 1.23% on last month and is 3.01% above the monthly target set for Dec. It is important to recognise that not all vacancies are being actively recruited to, and a large proportion of these vacancies are held on the establishment to support the Cost Improvement Programme (CIP).

A truer measure of vacancies is those posts being actively recruited to, based on the WTE of posts being advertised through NHS jobs. The active vacancy rate for Dec was 4.61% which is 1.36% above the monthly target of 3.25%.

The average time to recruit (between the authorisation date and the date that all pre-employment checks were completed) for Dec starters was 56 days (once international, Deanery and planned recruitment was excluded). The average 12 months rolling YTD position remains on target.

Average vacancies across LATTIN Trusts = 12.02% (latest data available)

Appraisals & Training: The non-medical appraisal rate decreased in Dec to 63% which is below both the monthly and yearly targets set. Reports of overdue and due appraisals are issued to managers monthly and included within the Divisional Board reports to ensure action is taken to complete appraisals within 12 months. This data will also be discussed with Execs for urgent remedial action. Conversely consultant appraisal rates currently stand at 80.00% which is a decrease of 1.90% on last month, with on-going work to support medical appraisals being undertaken. The Medical Revalidation Team is working collectively with all consultants to ensure the completion of all appraisals that are currently outstanding.
Average (Appraisal rate) across LATTIN Trusts = 74% (latest data available)

Turnover: Unplanned staff turnover (i.e. resignations) has increased slightly to 19.37% in Dec 2014 from the previous month. There were a total of 31 starters in the month of December and 582 voluntary leavers (rolling year Jan-Dec). This is 5.35% above the monthly target of 14.02% set for Dec 2014. Nursing and Midwifery, Support staff and Admin and Clerical make up over half of the Trust's total establishment and accounted for 18.77% of voluntary resignations in Dec. ESR Analysis shows the main reasons staff leave the Trust is for 'Work Life Balance' and Promotion and 'Relocation'. In response to the increase in leavers, Human Resources have conducted further in-depth analysis on turnover, leaving reasons and the length of service of leavers. Areas of most concern have been identified and action plans developed. A turnover report is being submitted to the Jan board which will seek to provide a deeper analysis of the increase in turnover within theTrust.
Average across LATTIN Trusts = 15.2% (latest data available)

LATTIN = London Acute Training Trusts (Imperial College, King's College, Royal Free Marsden, UCLH, Chelsea & Westminster, and Guy's).

Finance Balanced Scorecard

Chelsea and Westminster Hospital NHS Foundation Trust

Financial Performance

Financial Position (£000's)

	Full Year Plan	Plan to Date	Actual to Date	M9 YTD Var	M8 YTD Var
Income	(368,490)	(275,772)	(276,214)	441	510
Expenditure	334,653	249,107	255,426	(7,319)	(6,001)
EBITDA for FRR excl Donations/Grants for Assets	(33,837)	(26,666)	(19,788)	(6,878)	(7,491)
EBITDA % for FRR excl Donations/Grants for Assets	9.2%	9.7%	7.2%	-2.5%	-3.1%
Surplus/(Deficit) from Operations before Deprec	33,837	26,666	19,788	(6,878)	(7,491)
Interest	1,429	1,072	610	462	406
Depreciation	13,948	10,348	10,880	(532)	(539)
PDC Dividends	11,400	8,550	8,500	50	67
Retained Surplus/(Deficit) excl impairments	7,060	6,696	(292)	(6,988)	(7,549)
Impairments	0	0	0	0	0
Retained Surplus/(Deficit) incl impairments	7,060	6,696	(292)	(6,988)	(7,549)

Comments

Risk Assessment

Impact 5 – Loss of over £5.0m. Likelihood 3 – possible. Red

The YTD position is a deficit of £0.2m (EBITDA of 7.2%) which is an adverse variance of £6.9m against the budget.
The December is a surplus of £0.03m (EBITDA of 7.5%).

The Trust had planned to deliver a surplus of £0.2m in December based on the month 8 forecast, and is therefore £0.2m behind the monthly trajectory.

The year end forecast remains a surplus of £2.2m

Risk Rating (year to date)

COSR Rating	Weighting	M9 Planned Rating	M9 Actual Rating
Capital Servicing Capacity	50%	2	2
Liquidity	50%	4	4
Total Rating		3	3

Comments

The Trust recorded a Continuity of Service Rating (COSR) of 3 year to date at quarter 3 compared to a plan of 3. The capital service cover rating is a 2 (against a planned 2) and the liquidity rating is a 4 (against a planned 4).

Cost Improvement Programme

Division	YTD Identified	YTD Actual	YTD Variance	2014/15 Identified	Forecast Delivery	Forecast Variance
Total Planned Care	2,259	1,957	-302	3,080	2,729	-351
Total Emergency Care	1,084	772	-312	1,418	1,095	-323
Total W&N, CSY, HIV & SH	3,375	2,440	-935	4,956	3,540	-1,415
Total Facilities	2,089	2,089	0	2,784	2,784	0
Total ICT	207	207	0	284	284	0
Total Chief Nurse	235	235	0	315	315	0
Total HR & Education and Training	144	123	-21	192	181	-21
Total Procurement/Commercial	650	650	0	981	981	0
Total Finance	304	303	-1	491	490	-1
Unidentified	0	0	0	10,407	0	-10,407
2014/2015 CIP Total	10,296	8,815	-1,482	24,352	12,349	-12,519

Comments

The original CIP target was £24.9m (£18.9m in 14/15 + £6.0m brought forward from 13/14).

The year to date achievement is £8.8m (against a year to date target of £10.3m)
The forecast achievement is £12.3m (against an identified target of £14.5m)
The forecast CIP achievement is 3.3% less than 4% minimum requirement.

Key Financial Issues

Performance against control totals

In December the Trust reported a surplus of £0.03m bringing the year to date deficit to £0.2m. The Trust had planned to deliver a surplus of £0.2m in December based on the month 8 forecast, and is therefore £0.2m behind the monthly trajectory.

Primary Reasons for Current Month Position

NHS Clinical income is adverse against the control total by £0.2m due to Assisted Conception closure during Christmas period and £0.2m decrease in GUM activity
Private patient income is adverse against the control total by £0.1m mainly attributed to lower than expected PMU deliveries

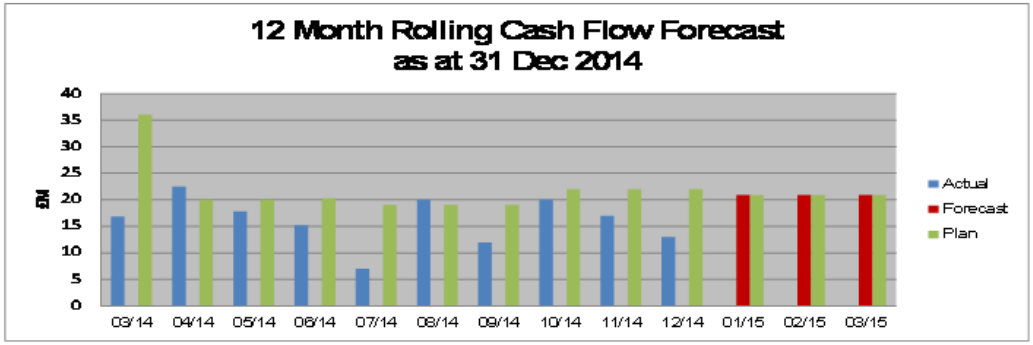
Key drivers behind the £6.9m overspend

- Unidentified CIPS (£8.5m)
- Private patient income under performance (£2.4m)
- Pay overspend, primarily due to high temporary staff usage in certain areas (£1.2m)
- Offset by over-performance on NHS clinical income (£3.3m)

Forecast

- The year end forecast remains a £2.2m surplus (as was reported in November).
- Further risks have been identified within the areas:
- £0.3m risk in Planned Care division relating to non-elective activity in quarter 4.

Cash Flow



Comments

The cash position at M9 is £12.8m compared to a plan of £22m. The principal causes are the level of debt which is yet to be recovered (Financial Control Contracting/activity staff meet on a daily basis to review the aged debt and to target specific debts for recovery action) and the Trust has a deficit of £0.2m against a planned surplus of £6.7m

Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Staff Recruitment and Retention/3.2.1/Jan/15
Purpose of paper	The purpose of this paper is to present to the Board the deeper analysis of the increase in turnover the Trust has experienced in the last year, the areas of focus, action taken to date, and next steps for discussion and approval.
Decision/action required/ recommendation	The Board is asked to: a) Note the Staff Turnover position, factors affecting this and actions to date b) Discuss and agree the recommended priorities and actions for improving the turnover and retention of staff, which will also form part of the 2015/16 People Strategy
Summary of the key risks/issues from the paper	Staff Turnover during 2014-15 has significantly increased, is high across the board but particularly at Band 2/3 (predominately HCAs) and Band 5 (predominately nursing and midwifery). The is due to a number of factors including: uncertainty around the Trust future causing instability, knock on effects of change in Executives and other senior positions, efficiency savings in corporate and others areas and local department/ward specific factors. A degree of turnover is healthy in attracting new talent and ideas. However, high turnover can be costly to the organisation both financially and in terms of patient care as significant investment in made in the recruitment, induction, training and development of staff in the early years of appointment. We need to retain the experienced staff we have invested in to become our leaders of the future. High turnover can also affect job satisfaction, work pressure, productivity and staff wellbeing and therefore in turn patient experience. Recruitment and Retention plans have been devised for hotspot areas where the turnover is high.
Link to corporate objectives	All Supports the “People” Enabler of the Trust’s strategy
Executive Sponsor	Susan Young, Chief People Officer and Director of Corporate Affairs

Chelsea and Westminster NHS Foundation Trust

Turnover Analysis for the period of 1st November 2013 - 31st Oct 2014

1.0 Introduction

1.1 Staff Turnover during 2014-15 has significantly increased, is high across the board but particularly at Band 2/3 (predominately HCAs) and Band 5 (predominately nursing and midwifery). The is due to a number of factors including: uncertainty around the Trust future causing instability, knock effects of change in Execs and other senior positions, efficiency savings in corporate and others areas and local department/ward specific factors.

1.2 A degree of turnover is healthy in attracting new talent and ideas. However, high turnover can be costly to the organisation both financially and in terms of patient care as significant investment in made in the recruitment, induction, training and development of staff, in the early years of appointment. We need to retain the experienced staff we have invested in to become our leaders of the future. High turnover can also affect job satisfaction, work pressure, productivity and staff wellbeing and therefore in turn patient experience. This paper provides the Board with a deeper analysis of the increase in turnover that the Trust has experienced in the last year, the areas of focus, action taken to date, and next steps for discussion and approval.

2.0 Decision/Action Required

2.1 The Board is asked to:

a) Note the Staff Turnover position, factors affecting this and actions to date, and
b) Discuss and agree the recommended priorities and actions for improving the turnover and retention of staff, which will also form part of the 2015/16 People Strategy

3.0 Background

3.1 Historically Chelsea and Westminster has had consistent levels of high turnover of around 14-16% (12/13: 14.60%; 13/14: 15.47%). Turnover is monitored and provided to the Board and Trust managers on a monthly basis and, alongside detailed exit data, provides a starting point to help analyse reasons why employees leave the trust. Turnover monitoring focuses on 'unplanned' turnover i.e. resignations rather than planned turnover, for example fixed term rotational doctors on a pan London training programme are excluded.

3.2 It has long been recognised that the Trust attracts a relatively young staff group and that staff leave predominantly for reasons related to promotion and relocation. The Trust is based in one of the most expensive parts of London and people relocate as they reach an age when they wish to invest in a home and/or start a family. In addition, the evidence shows that our younger workforce, particularly in bands 2-5, wish to diversify CVs and do so by taking the next career step at a different Trust. A number of benefits initiatives have been implemented by the HR team to help attract and retain staff which have received various awards over the last five years[1].

1 HR Awards include: Most Effective Benefits Strategy Award 2012; Best for Carers and Eldercare 2012, Best for Flexible Working Award 2012; Best for Childcare 2013, Top 30 Employers for Working Families 2012, 2013, 2014, ENEI (Employers Network for Equality and Inclusion) Bronze Award 2014

3.3 With few exceptions (e.g. NICU), the Trust has no problem in attracting new recruits and retains a strong brand and reputation in London. We received 18,625 applications in response to 856 adverts in 2014. Appendix 1 provides more detail on 2014 Recruitment.

3.4 During 2014/15 to date, turnover has seen a more marked increase than former years therefore requiring deeper analysis and action to improve the position. Analysis is done at Divisional and Team Level, by professional group and grade. We also examine data to show how long people are in post to understand workforce stability. The Appendices include summaries of local recruitment and retention action plans developed for key hotspot areas.

4.0 Turnover Analysis

4.1 Appendix 2 contains the detailed divisional analyses. Turnover is calculated as the number of unplanned leavers/ average headcount over the year. This is based on a rolling 12 month period. For example, October turnover rates are based on voluntary leavers in the 12 months up to and including October.

4.2 All planned leavers are excluded (junior doctors on rotation, fixed term appointees who leave at the end of their term, retirements, dismissals etc). But it should be noted that the figures would include those whose exits might have been expected at some stage, eg fixed term appointees who have left at any time before the expiry of their fixed term contract, and those who took another job elsewhere rather than be made redundant from the trust, eg colleagues from Finance who left prior to the redundancies which occurred as a result of outsourcing services. So it will never be a perfect measure, and we are discussing how we might present a more accurate picture of regrettable turnover (although the measure we use is currently the one used NHS-wide).

4.3 Following the October Board, more detailed analysis was commissioned for the year to 31 October 2014. The graphs and data tables in Appendix 2 show how the Trust turnover position has increased compared to previous years. Turnover for the year to October was 3.92% higher than in 2013, and is high in comparison to other London trusts.

4.4 Turnover has increased across all Divisions, with Corporate areas showing a more significant increase and Emergency & Integrated Care Division having the highest overall turnover. The following professional groups have the highest turnover: Additional Clinical Staff (Healthcare Assistants), Allied Health Professionals (eg therapists) and Nursing/ Midwifery. Actual numbers of starters and leavers are shown in the tables in Appendix 2.

4.5 The average length of service of our leavers is 3.42 years. For Corporate areas, 35.71% of all staff leave within 2 years of service whereas once staff have been at the trust for 10 years or more, the figure is much smaller at 6-8% across the trust. 45% of all staff leave Women's, Children's and Sexual Health within 2 years of service. For Planned Care, 53% of all staff leave Planned Care within 2 years of service.

5.0 Reasons for leaving/Exit Survey data

5.1 Reason for Leaving data show that the main reasons staff leave the Trust is for 'Work life Balance' and 'Relocation'. Exit surveys have also been carried out using email to contact former staff to complete a 'survey monkey' exit questionnaire. The data collected are shown

in the tables in Appendix 3. These show that staff leave the Trust predominantly for reasons of promotion/career development and location. A third of our leavers do not go on to another job. More than 10% leave to return to education/training, although this is much higher for the healthcare assistant group. 77% of people rated their experience of working here as "good" or "excellent". This, and the questions on appraisals, career development opportunities, recommendation of the trust and work/life balance are consistent with the responses to staff surveys which show much higher levels of staff engagement than other acute trusts, (top 20%) although not as high as we should aspire to.

5.2 A key question in the survey is that which asks whether the trust could have done anything to prevent the individual from leaving. In 41% of cases, the answer is "yes", and this needs further investigation. On a more positive note, over 75% say that if they were given the right opportunity they would return to the trust.

6.0 Retention Survey data

6.1 In 2014 when it became clear that turnover was starting to increase, we commissioned a piece of work on retention as opposed to exit, to try to understand better what could be done to prevent people from leaving. The directorates with the highest turnover were invited to participate in the study: therapies, midwifery, NICU, HR/OD, cancer services, finance, paediatrics, Rainsford Mowlem ward, theatres, adult outpatients and burns. Themes emerged as to why people would leave the trust:

- Lack of opportunities for career progression
- Low staff morale
- Unsupportive management
- Understaffing

Suggestions for improving job satisfaction were: Increase staffing levels, praise/recognise staff and provide training/team building.

6.2 The analysis suggests there is a lack of feedback, support and praise from management with responses such as 'More support required from Line Management.' and ' Feeling more appreciated and being criticised less' occurring frequently. Relationships are also key with people seeking more communication between management and clinical staff. people also wanted to be consulted more, with their ideas listened to, and their suggestions, opinions and concerns acted on. Responses suggested that people feel consulted, but not listened to. Career development and appraisal were also identified as areas for improvement, as were improved work/life balance (identified as reducing unpaid overtime and better management of rosters), and improved pay.

6.3 The latter is consistent with the findings in a TMP Worldwide report in 2014 which identified pay as a key factor when looking for a new job along with good work/life balance, opportunities for career progression, and investment in staff. That survey also showed that only 14% of nurses surveyed were happy in their current role, with 57% of respondents to that survey saying they were looking for a new role. So this trust is not alone in needing to cope with these sorts of retention issues. That survey also showed that the reputation of the trust was a key factor in attracting and retaining top nursing talent, which is reflected in the fact that for the majority of posts, we have no difficulty in attracting candidates who do state that the reputation of the trust was a key factor in their application.

6.4 Examples of actions from recruitment and retention plans are at Appendix 4.

7.0 Initiatives and Work in Progress to date

A People Strategy was drafted in 2014, and actions progressed which address the issues raised. The strategy is now being re-visited by the Board in the light of current data, and the new Corporate Directors' team is ensuring that we put "People First" as part of the approach to "Grip" and "Growth" for the trust. Key areas which are being progressed are:

- Executive and senior management walkabouts introduced to improve engagement and feedback
- Valuing and recognising our people – Star Awards, Thank you Awards etc
- Exit surveys are now being collected and data analysed (Appendix 3)
- Others surveys, such as the National Staff Survey and the Staff Friends and Family test (launched in 2014-15) inform wider local action plans and retention plans
- Use of retention surveys introduced in key hotspot ward/department areas
- Healthcare Assistant working group was set up with the Deputy Director of Nursing to review how to improve the role, experience and career pathway of HCAs. New HCA job descriptions have been written, quarterly recruitment campaigns were delivered and a new Care Certificate will be introduced in 2014-15.
- Over-recruitment of nurses and midwives, and introduction of rotational nursing posts to help provide nurses with a more varied programme of experience
- Focus on staff wellbeing: Dry January, Feelgood February, health MOTs, stress talks, smoking cessation support
- Improved staff benefits, and better promotion: "For who you are" newsletter
- Assessment of leadership development needs carried out
- Approach to Talent Management piloted

6.0 Suggested Next Steps to Agree

- People Strategy actions and plans to be monitored by the new People Committee
- Renewed focus on leadership development, procurement of partner/partners to deliver this
- Roll out new approach to Talent Management
- Loyalty, recruitment and retention incentives to be explored e.g. Loyalty payment/gift for HCAs and possibly Band 5 nurses after one to two years' service.
- Staff Bank rates to be increased. (Many nurses and HCAs supplement their pay with additional bank work therefore this will be an incentive for staff, and a cost reduction on agency spend for the trust.)
- Continue to promote staff benefit packages to staff so staff realise the many additional benefits of working at the Trust and optimise use of this.
- Funded training courses and development with caveat need to repay if leave Trust within a certain time period – existing policy to be enforced to tie people in
- Alumni to set up to keep in touch with and encourage returners

Susan Young, Chief People Officer and Director of Corporate Affairs

22 January 2015

Appendix 1: Recruitment Analysis (Calendar year 2014)

Facts and Figures (January to December 2014)

- 856 adverts posted on NHS jobs in 2014.
- 18,625 applications received via NHS jobs.
- 818 job offers made
- 787/818 candidates (96%) successfully processed through to commencement
- 665/787 (85%) were external candidates and 122/787 (15%) were internal
- Average time to recruit (time from authorisation of post to completion of the offered candidates' pre-employment checks) was 55 days, against a target of 55 days.

Initiatives undertaken in 2014

- Active involvement in London HR Streamlining Project which aims to reduce time to hire by more efficient pre-employment checks/processes across London Trusts,
- Introduction of single NHS references from the most recent employer instead of a full three year working history. This applies to moves to NHS from any other NHS body.
- Internal recruitment – reduced or eliminated the requirement of references for internal moves or promotions. Many internal moves can now take place immediately.
- Self-certification for some occupational health checks,
- Electronic Disclosure and Barring Service (formerly CRB) checks
- Introduction of ID scanners, to improve ID checks processes in recruitment and bank offices. The scanners are similar to those used by the UKBA and can detect fraudulent passports, thereby preventing fraud and further post employment issues.
- HCA recruitment – generic HCA recruitment has been run quarterly in 2014, with vacancies for all areas being recruited centrally. This has resulted in a time saving for managers by interviewing large numbers on one day, rather than departmentally, and has created a steady supply of HCA candidates for placements on wards.
- Pre-employment checks for HCAs mostly now completed on the interview day
- Communities into Training and Education (CITE) pilot programme to source candidates for HCA posts. (Not-for-profit body working to get long term unemployed back into work. CITE candidates take preliminary literacy and numeracy test and initial training, with the guaranteed interview with us at the end. This programme resulted in 10 offers of employment being made)
- Generic nursing recruitment – the Trust undertook a large planned over-recruitment of newly qualified nurses graduating in September 2014. C.80 offers were made and 53 commenced work with the Trust in October and November 2014.
- Newly introduced medical and surgical rotation posts were very attractive to applicants and we hope the rotations will improve retention.

Nursing, Midwifery and Clinical Support staff recruited in 2014

Staff Group	Band	Number Recruited in 2014
HCA	Band 2 & 3	103
Nursing	Band 5	216
	Band 6	59
	Band 7	15
Midwifery	Band 5	27
	Band 6	5
	Band 7	1
Total		Total: 426

APPENDIX 2: Trust and Divisional Position (as at 31st October 2014)

Table 1a: Trust turnover by month

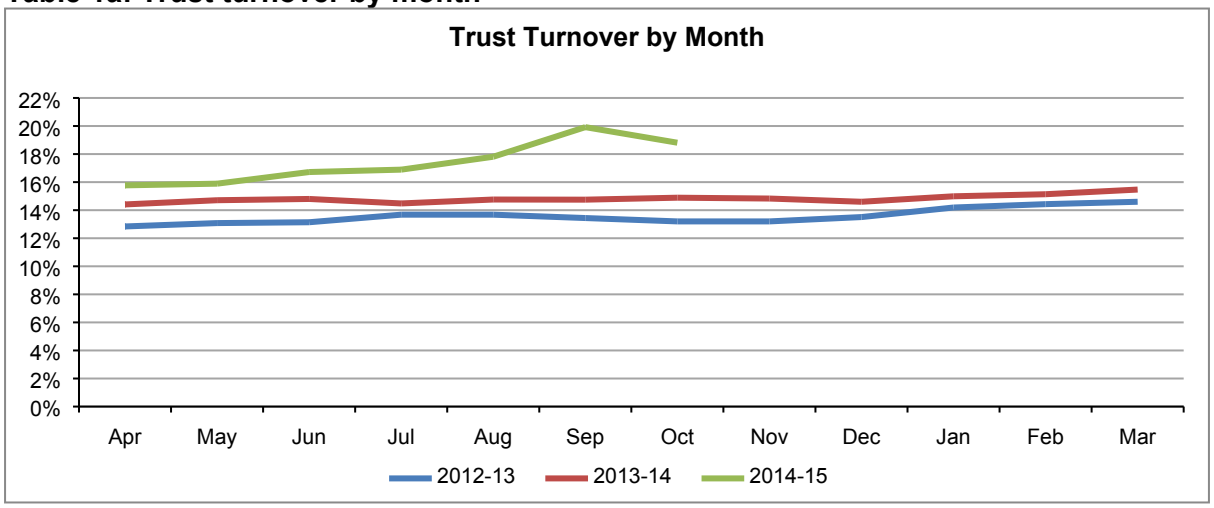


Table 1b: Turnover by division and professional group

Turnover by Division	Oct-13	Oct-14	Variance
Corporate	12.87%	20.65%	7.78%
Emergency & Integrated Care	17.49%	20.88%	3.39%
Women, Children & Sexual	15.41%	18.53%	3.12%
Planned Care	14.13%	17.27%	3.14%
Trust	**14.89%**	**18.81%**	**3.92%**
Turnover by Staff Group	**Oct-13**	**Oct-14**	**Variance**
Add Prof Scientific and Technic **(pharmacy, technicians and practitioners)**	15.29%	18.08%	2.79%
Additional Clinical Services **(HCA's, Healthcare - Support Staff)**	17.86%	28.06%	10.20%
Administrative and Clerical	11.86%	15.58%	3.72%
Allied Health Professionals **(dieticians, physiotherapists, occupational therapists, radiographers)**	15.77%	22.42%	6.65%
Healthcare Scientists **(Healthcare scientist practitioner and healthcare scientist)**	8.60%	9.52%	0.92%
Medical and Dental	11.48%	10.64%	-0.84%
Nursing and Midwifery	16.97%	19.96%	2.99%
Trust	**14.89%**	**18.81%**	**3.92%**

Corporate Division Turnover Analysis

Service	Avg Headcount	Starters	Leavers	Unplanned Turnover (%)
Information Service	12	3	5	41.67
Research & Development Service	14	0	5	35.71
Finance Service	85	12	26	30.59
Human Resources & OD Service	71	14	17	23.94
Public Affairs	5	0	1	22.22
Chelsea Wing	36	6	6	16.90
Governance & Corporate Affairs Service	12	3	2	16.67
Nursing & Patient Affairs Service	23	1	3	13.04
Chief Executive Service	10	3	1	10.53
Information Mgmt & Technology Service	51	8	4	7.92
Estates and Facilities	16	3	0	0.00
Total	**333**	**53**	**70**	**21.05**

Over the past year, two significant organisational change processes have had an impact. Finance Transformation – the Trust outsourced transactional finance and procurement services to SBS which resulted in 45 staff being placed at risk of redundancy. Staff were been aware this was coming, and many were proactive in seeking alternative employment. IT Shared Services – We are in the process of establishing a Shared Service with the Royal Marsden. It is proposed that 33 IT staff will TUPE transfer to a new company in March 2015. Some staff have now moved to other NHS Trusts rather than transfer to the new company.

Clinical Coding is a challenging area for the Trust to recruit and retain staff and turnover remains consistently high. This is a hard to recruit group, and staff are often a transient workforce throughout London. It can be more lucrative for Coders to work via agencies and/or contract their services. This has been recognised as an issue and an additional £100,000 was invested into the Clinical Coding Services.

A retention survey was conducted within HR and OD to establish possible reasons for any increase in turnover. Workload has been cited as an issue compounded by the need to make corporate HR CIPs whilst experiencing an increase in the need for HR support.

Corporate Division: Leavers by Length of Service

Service	0-1 yrs	1 - 2yrs	2-3 yrs	3-5 yrs	5-10 yrs	Over 10 yrs	TOTAL
Chief Executive Service	0	0	0	0	1	0	**1**
Estates and Facilities	0	0	0	0	0	0	**0**
Finance Service	5	4	3	8	3	3	**26**
Governance & Corporate Affairs Service	0	0	1	1	0	0	**2**
Human Resources & OD Service	6	2	4	1	3	1	**17**
Information Service	0	1	0	2	2	0	**5**
Public Affairs	0	0	1	0	0	0	**1**
Information Mgmt & Technology Service	0	1	0	2	1	0	**4**
Nursing & Patient Affairs Service	0	0	1	0	2	0	**3**
Chelsea Wing	1	2	2	0	1	0	**6**
Research & Development Service	0	3	1	0	1	0	**5**
	12	**13**	**13**	**14**	**14**	**4**	**70**

Emergency & Integrated Care Division Turnover Analysis

Service	Avg Headcount	Starters	Leavers	Unplanned Turnover (%)
David Erskine	22	9	9	40.91
Medicine Outpatients	9	2	3	33.33
Edgar Horne	25	7	8	32.00
Therapy Services	156	28	39	25.00
Specialist Nurses	38	6	7	18.67
Nell Gwynne	40	9	7	17.72
Accident & Emergency	99	46	17	17.26
Acute Assessment Unit	65	22	11	17.05
Medicines Management	39	8	6	15.38
Oncology	20	9	3	15.38
Medical Specialities	36	49	5	13.89
Dietetics	24	2	3	12.77

David Erskine ward has had the most significant turnover Further analysis shows that over half of the leavers (5) were band 2 Health Care Assistants; 3 went on to further their careers (medical school/ clinical assistant), one went to another role in the Trust. Further analysis is taking place on Edgar Horne ward includes 5 leavers at band 5. Senior walkabouts are being carried out to help engage and get a sense of ward morale to add to the quantitative data.

The Emergency Department has a turnover rate of 17.26%; and coupled with the planned expansion of the unit in 2015, a recruitment and retention plan is underway to ensure we recruit and retain all staff groups (medical, nursing and admin).

Therapy services (25% turnover) has also been a hotspot. A recruitment and retention plan was put in place in September 2014, which included the expansion of band 6 physiotherapy and O/T rotation programmes and a local survey to explore retention, employee satisfaction and career development. The key themes identified from the qualitative data are outlined in the attached paper and work is currently underway to address the issues raised.

Leavers by Length of Service

Service	0-1 yrs	1 - 2yrs	2-3 yrs	3-5 yrs	5-10 yrs	Over 10 yrs	TOTAL
Accident & Emergency	2	4	2	5	3	1	**17**
Acute Assessment Unit	2	2	1	4	1	1	**11**
David Erskine	3	4	1	0	1	0	**9**
Edgar Horne	2	2	1	3	0	0	**8**
Medical Specialities	4	0	0	1	0	0	**5**
Medicines Management	0	1	0	3	1	1	**6**
Medicine Outpatients	0	1	1	0	1	0	**3**
Nell Gwynne	2	0	1	4	0	0	**7**
Oncology	0	0	1	0	2	0	**3**
Specialist Nurses	3	0	0	0	2	2	**7**
Dietetics	0	0	2	0	1	0	**3**
Therapy Services	7	5	11	11	4	1	**39**
	25	**19**	**21**	**31**	**16**	**6**	**118**

Women's, Children's and Sexual Health Division Turnover Analysis

Service	Avg Headcount	Starters	Leavers	Unplanned Turnover (%)
ACU	17	5	6	36.36
Private Maternity	14	2	4	29.63
Ron Johnson	28	5	8	29.09
Charing Cross Hosp WLCSH	42	6	10	24.10
Dermatology	35	7	8	23.19
John Hunter Clinic	42	10	9	21.69
Paediatrics	299	116	63	21.11
Kobler Day Care	11	3	2	19.05
56 Dean Street	85	25	15	17.75
Maternity	310	57	54	17.45
Neonatal Intensive Care	116	40	20	17.24
St Stephens Centre Mgt	30	12	4	13.33
Kobler Outpatients	16	0	2	12.90
HIV/GUM Research	18	3	1	5.71
Obs & Gynae	64	32	3	4.72
Research Laboratory	4	1	0	0.00
Total	**1125**	**324**	**209**	**18.59**

Paediatrics is of particular concern, especially as the figures show that 63 staff left over the year with 17% leaving within 12 months of starting, a retention plan has therefore been drafted following a meeting with the Paediatric senior nursing team, further data will be analysed to identify any trends with where individuals are leaving within the first 12 months.

Midwifery and NICU have high numbers leaving each year so have specific and ongoing recruitment and retention plans in place, including plans for overseas recruitment. The recent midwifery staff retention survey showed that staffing levels and skill mix are the predominant issue raised by staff. Recruitment has been a focus for the last quarter, and vacancies rates have been reduced.

Feedback, including the CQC report, shows relationships and communication at work issues in NICU which are being addressed. Staff shortages have also been an issue on the unit exacerbated by a national shortage.

Whilst ACU and Private Maternity account for the highest turnover percentages, these relate to relatively small numbers of staff so further information needs to be collected to review if there are any specific themes emerging and ensure that exit surveys are documented.

Women's, Children's and Sexual Health Division: Leavers by Length of Service

Service	0-1 yrs	1 - 2yrs	2-3 yrs	3-5yrs	5-10 yrs	Over 10 yrs	TOTAL
Neonatal Intensive Care	6	3	7	1	2	1	**20**
Paediatrics	17	12	11	10	8	5	**63**
56 Dean Street	3	7	1	3	0	1	**15**
Charing Cross Hosp WLCSH	2	1	2	2	3	0	**10**
Dermatology	2	2	1	1	1	1	**8**
HIV/GUM Research	0	1	0	0	0	0	**1**
John Hunter Clinic	2	3	1	0	2	1	**9**
Kobler Day Care	0	1	1	0	0	0	**2**
Kobler Outpatients	1	0	0	0	0	1	**2**
Research Laboratory	0	0	0	0	0	0	**0**
Ron Johnson	1	3	3	1	0	0	**8**
St Stephens Centre Mgt	1	0	0	2	0	1	**4**
Private Maternity	1	1	0	0	2	0	**4**
ACU	1	1	1	2	1	0	**6**
Maternity	9	11	15	11	7	1	**54**
Obs & Gynae	2	1	0	0	0	0	**3**
	48	**47**	**43**	**33**	**26**	**12**	**209**

Planned Care Division Turnover Analysis

Service	Avg Headcount	Starters	Leavers	Unplanned Turnover (%)
Rainsford Mowlem	27	21	11	41.51
Surgical Specialist Nurses	3	0	1	33.33
Theatres	113	27	28	24.89
Endoscopy Service	25	7	6	24.49
Phlebotomy Service	14	0	3	22.22
Treatment Centre Service	60	7	13	21.85
Burns Unit Division	58	9	12	20.69
Pharmacy	129	24	23	17.83
Surgical Specialities	67	80	11	16.42
Cardiology Diagnostics	13	2	2	16.00
Lord Wigram	27	10	4	15.09
Intensive Care Service	69	9	10	14.60
Imaging Service	125	22	18	14.46
Adult Outpatients	97	20	13	13.40
Anaesthetics	52	63	6	11.65
David Evans	30	2	3	10.17
Surgery Management Division	24	0	2	8.33
Sterile Services	29	1	0	0.00
Total	**956**	**304**	**166**	**17.36**

The above table demonstrates that the Rainsford Mowlem has had the most significant turnover. A number of reasons have been given by staff who left on their termination forms. A questionnaire is being developed to send to staff who have left in order to give them further opportunity to expand on their time on the ward. The ward has also been reconfigured over the last month as it was felt that the size of the ward and the fact that additional beds were being used for escalation purposes had a detrimental effect on staff and patient experience. The ward has now been moved to the old St Marys Abbotts site whilst Rainsford's previous site is being used as a step down ward which means the bed base has now reduced and this will be reviewed to see what impact this may have on turnover.

There are a number of initiatives now being looked at in theatres to try to address issues there including sending questionnaires out to former employees, standardising some of the working patterns in theatres and the potential to send out a local staff survey to existing staff with specific questions relating to current staff experience.

The high turnover in Specialist Nursing and Phlebotomy is due to the small head count in the service, whilst the high turnover in Endoscopy seems to relate to Band 5 Nursing and this is currently being reviewed to understand any issues that may currently exist.

Pharmacy does not have a specific plan presently but will be kept under review. The numbers this year relate mainly to change management issues, i.e. some staff whose posts would have been affected by the pharmacy outsourcing plan decided to leave and were not replaced as otherwise the post would have been TUPE'd to the new provider.

Leavers by Length of Service

Service	0-1 yrs	1 - 2yrs	2-3 yrs	3-5 yrs	5-10 yrs	Over 10 yrs	TOTAL
Adult Outpatients	5	1	0	1	3	3	**13**
Anaesthetics	2	3	0	0	1	0	**6**
Cardiology Diagnostics	1	1	0	0	0	0	**2**
Endoscopy Service	4	1	1	0	0	0	**6**
Imaging Service	2	2	4	4	6	0	**18**
Phlebotomy Service	1	0	1	0	1	0	**3**
Sterile Services	0	0	0	0	0	0	**0**
Intensive Care Service	3	1	2	3	1	0	**10**
Theatres	6	9	3	5	2	3	**28**
Treatment Centre Service	3	4	1	1	3	1	**13**
Pharmacy	2	4	7	4	4	2	**23**
Burns Unit Division	4	6	0	0	1	1	**12**
David Evans	1	2	0	0	0	0	**3**
Lord Wigram	2	1	0	1	0	0	**4**
Rainsford Mowlem	4	3	0	1	1	2	**11**
Surgery Management Division	1	0	0	0	1	0	**2**
Surgical Specialist Nurses	0	0	0	1	0	0	**1**
Surgical Specialities	6	3	0	0	1	1	**11**
	47	**41**	**19**	**21**	**25**	**13**	**166**

Appendix 3: Employee Exit Questionnaire (excluding comments)

Are you going on to another post?

Answer Options	Response Percent	Response Count
Yes	68.1%	126
No	33.0%	61

Please select the option that best describes your plans for the immediate future.

Answer Options	Response Percent	Response Count
NHS Trust	53.2%	100
Private Healthcare Organisation	7.4%	14
Non-Health Industry	4.8%	9
Self-Employed	3.7%	7
Retirement	3.7%	7
Travel	3.2%	6
Return to education/training	10.6%	20
Parental/carer responsibilities	1.6%	3
Other	11.7%	22
Other (please specify)		26

What was your primary reason for leaving the Trust?

Answer Options	Response Percent	Response Count
Promotion/career development	35.5%	66
Relationship with colleagues	3.2%	6
Working hours	4.3%	8
Location	17.2%	32
Change of industry/career	2.2%	4
Relationship with manager	2.2%	4
Salary/benefits	2.7%	5
Education/training opportunities	9.7%	18
Other	23.1%	43
Other (please specify)		55

Overall, how would you rate your experience of working here?

Answer Options	Response Percent	Response Count
Excellent	21.3%	40
Good	55.3%	104
Fair	17.6%	33
Poor	5.9%	11

Did you receive an Appraisal/KSF Review?

Answer Options	Response Percent	Response Count
Yes (within 12 months)	60.0%	111
Yes (over 12 months ago)	15.7%	29
No	24.3%	45

How would you rate your opportunities for career development within the Trust?

Answer Options	Response Percent	Response Count
Excellent	9.1%	17
Good	31.2%	58
Fair	34.9%	65
Poor	24.7%	46
Do you have any comments about your career development during your time here?		62

How would you rate the Trust's ability to accommodate your work/life balance (for instance through flexible working?

Answer Options	Response Percent	Response Count
Excellent	13.4%	25
Good	43.5%	81
Fair	30.1%	56
Poor	12.9%	24
Do you have any comments on your work life balance during your time at the Trust?		34

Please rate the appropriate box for the following areas:

Answer Options	Always	Frequently	Sometimes	Never
I felt my opinions and suggestions were listened to and valued	25	64	84	16
Expectations were clearly set out & communicated to me	29	75	73	10
My manager was approachable & available	79	51	48	11
My performance & accomplishments were recognised	32	62	74	21
I was provided with performance feedback	28	50	87	23
Teamwork was encouraged within the team	57	64	53	14
My manager showed empathy & support	66	65	45	12
My concerns were listened to and acted upon	39	53	74	21
The Trust is committed to safety in the workplace	64	83	38	2

Could the Trust have done anything to prevent you from leaving?

Answer Options	Response Percent	Response Count
Yes	41.3%	78
No	58.7%	111
Please provide further comments below		83

Given the right opportunity, would you consider returning to the Trust in the future?

Answer Options	Response Percent	Response Count
Yes	75.7%	140
No	24.3%	45
Please provide further comments below		45

I would recommend the Trust as a place to work.

Answer Options	Response Percent	Response Count
Strongly agree	23.3%	44
Agree	39.7%	75
Neither agree or disagree	24.9%	47
Disagree	7.9%	15
Strongly disagree	4.2%	8

If a friend or a family member needed treatment, I would be happy with the standard of care provided by this organisation

Answer Options	Response Percent	Response Count
Strongly agree	34.6%	65
Agree	43.1%	81
Neither agree nor disagree	19.1%	36
disagree	2.1%	4
Strongly disagree	1.1%	2

Do you feel the Trust upheld its values (kind, safe, respectful and excellent) during your time here?

Answer Options	Response Percent	Response Count
Yes	76.3%	142
No	23.7%	44
If not, why not?		50

Appendix 4: Extracts from Recruitment and Retention Plans

Future recruitment initiatives

- Continue to play an active part in pan-London HR streamlining programme
- Confirmations of employment/factual references – the final phase of the recruitment streamlining programme is to move from the current style of personal employment references to factual references (also known as confirmations of employment), giving only dates of employment and any absence and disciplinary information on the candidate. These will be returned quicker, reducing time to hire. Additionally they also reduce the workload of managers in eliminating the need to respond to reference requests from other Trusts. This will require buy in to fully implement across the Trust and reap the benefits in the time to recruit.
- HCA recruitment – generic HCA recruitment will be run every two months in 2015, responding to the increased turnover in the staff group.
- Continue CITE recruitment programme
- Generic nursing recruitment – frequency will also be increased in 2015. The exact level of over-recruitment of newly-qualified nursing and midwifery staff will be decided as part of the 2015/16 business and workforce planning round
- Increased induction – this has been increased to twice per month from April 2015 onwards.

Extracts from Divisional Retention Plans

- Rotational posts and new recruits in therapies
- Rainsford Mowlem ward re-configured
- Midwifery probationery meetings scheduled at start of employment
- Care Certificate being developed for Midwifery support workers
- Enhanced pay rates in NICU
- Golden hellos/introduce a friend scheme for Emergency Department
- Theatres standardising working patterns/on call
- Promotion of travel/season ticket loans

Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Monitor In-Year Reporting & Monitoring Report Q3/3.3/Jan/15
Purpose of paper	To keep the Board informed of submission of commentary to Monitor on the Quarter 3 2014/15 in year financial return.
Decision/action required/ recommendation	The Trust Board is asked to: 1. Delegate approval to the Chief Financial Officer to approve, on behalf of the Board, submission of the Quarter 3 2014/15 in-year financial reporting return to Monitor. 2. Approve the commentary for the submission to Monitor 3. Approve the In Year Governance Statement (attached in Appendix 1) which includes the following elements: - Approve the financial declaration that the Trust will continue to maintain a continuity of service rating of at least 3 over the next 12 months - Approve the Governance Declaration, that the Trust has plans in place to achieve ongoing compliance with all existing targets 4. Approve the capital expenditure declaration, that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the reforecast plan.
Summary of the key risks/issues from the paper	**Financial Performance** The Trust achieved a net deficit of £0.2m for the year to date compared against the reforecast plan of a breakeven position. The year to date EBITDA was £19.8m (7.2%) against a plan of £20.0m (7.2%) for the year to date. The overall COSR is based on two ratios capital serving capacity ratio and liquidity; was 3 compared against a plan of 3. **Targets and Indicators** The Trust did not achieve the following indicator in the third quarter of the 2014: Referral to treatment time 18 weeks admitted patients 83.8% (target 90%)
Link to corporate objectives	Ensure Financial and Environmental Sustainability Deliver 'Fit for the Future programme'
Executive Sponsor	Lorraine Bewes, Chief Financial Officer

Monitor In-Year Reporting & Monitoring Report Q3

1. Introduction/ Background

1.1. A financial reporting return and commentary are required to be submitted to Monitor on a quarterly basis. This report provides commentary to be submitted with the financial return for the quarter ending December 2014.

2. Decision/Action required

2.1. The Trust Board is asked to:

2.1.1. Delegate approval to the Chief Financial Officer to approve the submission of the Quarter 3 2014/15 in-year financial reporting return to Monitor, on behalf of the Board.

2.1.2. Approve the commentary for the submission to Monitor

2.1.3. Approve the In Year Governance Statement (attached in Appendix 1) which includes the following elements:

- Approve the financial declaration that the Trust will continue to maintain a continuity of service rating of at least 3 over the next 12 months
- Approve the Governance Declaration that the Board, is 'satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards':

2.1.4. Approve the Capital Expenditure declaration statement that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the reforecast plan.

3. Content

3.1. **Governance Declaration**

3.1.1. **Continuity of Service Rating (COSR):** The Trust recorded a Continuity of Service Rating (COSR) of 3 year to date at quarter 3 compared to a plan of 3. The capital service cover rating is a 2 (against a planned 2) and the liquidity rating is a 4 (against a planned 4).

3.1.2. **Compliance with targets:** The Trust did not achieve the overall target for RTT standard for admitted patient pathways in Q3, with performance of 83.8% (target 90%); however the target was achieved in December 2014. The Trust met the RTT standards for non-admitted and incomplete pathways in Q3, and is planning to achieve all three RTT indicators in Q4. The Trust is meeting all the remaining performance indicators at the end of quarter 3.

3.1.3. The Board is 'satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards':

3.1.4. The Trust had identified a risk to delivery of the Referral to Treatment Time (RTT) standard for admitted patients in 2014/15 and has been working with support from local commissioners and NHS England to reduce the backlog of long waiting patients, with a planned drop in performance for quarters 1-3. The Trust has reduced the number of patients waiting over 18 weeks for admitted treatment from over 1,300 in April 2014 to c220 at the end of December 2014.

3.2. In the third quarter of 2014/15 there were elections to fill posts on the Council of Governors, there was one resignation from the Council of Governors and there were no changes to the Council of Governors stakeholder appointments (Appendix 2).

3.3. **Capital Declaration**

3.3.1. The year to date capital spend is reported at £11m against the plan of £13m, a variance of £1.8m (14% behind plan).

3.3.2. The major schemes in progress in this financial year are ED refurbishment, Pathology & Research Lab, Medicinema and Reconfiguration of Medical Day Unit, Discharge and Transport Lounge. The expenditure for the major schemes is reported under Property, Plant and Equipment, with other expenditure ahead of plan by 28%. The Pathology Lab is complete and operational and is capitalised in Quarter 3. Other buildings and IT schemes are being worked on and the expenditure will be incurred in future quarters. The Property maintenance expenditure is behind the plan by 12%.

3.3.3. Capital spend on information technology is 39% behind plan and purchase of intangible assets is 58% behind plan. This is primarily due to slippage on several projects e.g. EPR Replacement (£0.9m), IT Strategy Implementation (£0.3m), Patient Relationship Management (£0.3m) and Electronic Document Management (£0.2m). The majority of the expenditure is now planned to be incurred in Quarter 4 for IT projects.

3.3.4. Plant & Equipment capital expenditure (other equipment) is behind the plan by 14%. The equipment replacement programme is in place and the major expenditure relates to Imaging both for the Emergency Department Redevelopment and Radiology Department, which will be incurred in Quarter 4.

Monitor Categories	YTD Budget	YTD Actual	YTD Variance	YTD Variance
	£'000	£'000	£'000	%
Building Maintenance and Other Building Projects	2,718	2,387	331	12%
Plant and Equipment - Information technology	4,170	2,548	1,622	39%
Plant and Equipment - other equipment	907	777	130	14%
Property - new land, buildings or dwellings	0	0	0	0%
Property, plant and equipment - other expenditure	3,663	4,703	-1,040	-28%
Purchase of intangible assets	1,290	548	742	58%
	12,747	**10,963**	**1,784**	**14%**

3.4. **Summary of Financial Position**

3.4.1. In quarter 3, the Trust reported a surplus of £0.6m (against a Q3 reforecast of £0.8m) and a net deficit of £0.2m for the year to date, against the reforecast plan of a breakeven position. The EBITDA was £19.8m (7.2%) against the Q3 reforecast a plan of £20.0m (7.2%) for the year to date.

3.5. **Statement of Comprehensive Income**

NHS Clinical Revenue

3.5.1. The underlying NHS clinical income is £0.6m behind the reforecast plan in Q3 and £0.6m behind plan for the year to date.

3.5.2. Elective and day case activity is £0.2m ahead of plan in Q3 primarily as a result of increased surgical work associated with the planned clearance of long

waiting patients on referral-to-treatment (RTT) pathways, particularly in Trauma and Orthopaedics.

3.5.3. Non Elective activity is £0.3m ahead of plan in Q3, largely the result of the discharge of a number of long stay Paediatric Gastroenterology patients in December. The Trust is continuing to under-perform on specialised activity, which is not subject to the block funding, partly offset by higher numbers of obstetric deliveries than plan.

3.5.4. Outpatient income is £0.7m behind the reforecast plan for Q3. GUM activity continued to over-perform, albeit at a slower rate in December, but this is off-set by under-performances in a number of Paediatric specialties and in Therapies.

3.5.5. NHS Clinical Income for other points of delivery is in line with plan in the quarter and for the year to date. Excluded drugs are £0.4m ahead of plan for the quarter, which is offset by an over spend on non-pay expenditure. Critical care activity is £0.3m behind plan in Q3 particularly in adult and burns critical care and NICU but this is partly off-set by an over-performance in Paediatric HDU. A&E and UCC attendances are in line with the reforecast plan in Q3.

Other Operating Income

3.5.6. Private Patient income was below the Q3 reforecast by £0.1m this is attributed to lower than expected deliveries in the private maternity unit (December the deliveries were down by 9 against the re-forecast plan) and the average income per delivery was down. Non protected clinical income is ahead of the Q3 reforecast by £0.4m this is primarily related to over-performance in local authority GUM income.

3.5.7. Research and development income is behind the Q3 reforecast by £0.5m related to a reduction in expenditure; the expenditure is ahead of the Q3 reforecast by £0.6m. This is due to a review of projects in Q3. Education and Training income is ahead of the Q3 reforecast plan by £0.2m this relates to £0.1m related to LDA income for one-off non recurrent funding and additional resuscitation training income above the forecast.

3.5.8. Other Operating revenue is ahead of the Q3 reforecast by £0.6m. The Q3 reforecast assumed TDA income of £1.1m (offset against consultancy costs), however the income reported for December was only £0.4m, an adverse variance of £0.7m. This is mainly related to phasing of the projected spend. This was offset against additional income assumed within other operating revenue for winter pressures £0.5m, £0.4m for ICT shared service project recharged to the Royal Marsden and £0.1m related to additional pharmacy income.

Operating Expenditure

3.5.9. Pay - There was an adverse variance against the Q3 reforecast by £0.18m. The permanent staff is overspent by £0.4m and the temporary staff was underspent by £0.2m. There was a significant increase in permanent staff in the third quarter due to 80 nurses and midwifes coming into post since October, this has been offset partially by a reduction in bank/agency hours to cover vacancies. There was a significant reduction in temporary bank/agency usage in December of c. 8000. The over-spent relates to other pay agency costs some of which includes ICT shared service which is offset against other income.

3.5.10. Drugs – There is an adverse variance of £0.3m in the quarter, this is comprised of £0.4m adverse variance for drug exclusions (which is offset against

other income), and £0.1m underspend in tariff drugs costs. Clinical supplies are overspent by £0.15m against the Q3 reforecast this continues to be driven by activity pressures including the RTT backlog clearance.

3.5.11. Non-clinical supplies are overspent by £0.8m in the quarter this is mainly driven from £0.5m relates to the ICT shared service and TDA costs (which are offset against other income). The remainder of the overspend relates to an increase in bad debt provisions in the third quarter. Consultancy is underspent by £0.8m driven due to lower than expected TDA costs £0.7m, and £0.1m general reduction in other areas.

3.5.12. There is an under-performance against the CIP plan of £0.1m for the Q3 in pay and clinical supplies CIP in diagnostic demand management and workforce schemes, and £0.1m related to the revenue generation schemes related to slippage in private patient growth income.

3.6. **Statement of Financial Position**

3.6.1. **Property Plant and Equipment:** The capital plan for 2014/15 is £28.6m. The year to date capital expenditure year is £6.8m against the Trust plan of £9.0m, £2.2m behind the plan. This is 76% of the latest capital year to date spend, and therefore triggered the requirement of a capital reforecast.

3.6.2. **Receivables and Other Current Assets:** As at December 2014 was £65.4m (against a plan of £30.6m). The top ten debtors outstanding of £7.6m relate principally to NHS organisations and Department of Health.

3.6.3. **Trade and Other Payables - Current:** The total trade and other payables, accruals and other current liabilities was £40.5m against a plan of £37.5m.

3.6.4. **Cash Flow:** The cash balance at the end of quarter 3 is £12.4m against a plan of £22.0m, primarily driven by the movement of working capital and I&E shortfalls.

3.7. **Forecast**

3.7.1. The current mitigated forecast is for a £2.2m surplus for the Trust (which is a £4.9m adverse variance against a £7.1m planned surplus). This mitigated forecast would achieve a continuity of service rating of 3.

4. Summary

4.1. **Financial Performance**

4.1.1. The Trust reported a net deficit of £0.2m for the year to date, against the reforecast planned breakeven position. The EBITDA was £19.8m (7.2%) against a plan of £20.0m (7.2%) for the year to date.

4.1.2. The Trust has achieved a year-to-date (YTD) Continuity of Service Rating (COSR) of 3 as at 31st December 2014, which is in line with plan. Within this, the liquidity element achieves a score of 4, and the capital servicing ratio a score of 2.

4.2. **Targets and Indicators**

4.3. The Trust did not achieve the referral to treatment time 18 weeks for admitted patients in the third quarter, with performance of 83.8% (target 90%) for admitted patients. The Trust is meeting all the remaining performance indicators at the end of quarter 3.

Appendix 1 – In Year Governance Statement

In Year Governance Statement from the Board of Chelsea and Westminster

The board are required to respond "Confirmed" or "Not confiirmed" to the following statements (see notes below)

	For finance, that:	**Board Response**
4	The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.	Confirmed
	For governance, that:	
11	The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	Confirmed
	Otherwise:	
	The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 22, Diagram 6) which have not already been reported.	Confirmed
	Consolidated subsidiaries: Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.	0

Signed on behalf of the board of directors

Signature	Sign Here.	Signature	Sign Here.
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Appendix 2

In the third quarter of 2014/15:

I. ELECTIONS

There were elections to fill posts on the Council of Governors.
There was one resignation from the Council of Governors.
There were no changes to the Council of Governors stakeholder appointments.

II. BOARD OF DIRECTORS

There have been changes to the Board of Directors.

Following expiry of the term of office of Sir John Baker, Non-executive Director 31.10.14 and Jeremy Loyd, Non-executive Director 31.10.14 their terms of office have been extended for a further year by the Council of Governors 05.12.14.

Following expiry of the term of office of Karin Norman, Non-executive Director 31.10.14 Eliza Hermann has been appointed as a full voting Non-executive Director as of 01.11.14.

Following expiry of the term of office of Professor Richard Kitney 31.10.14 Dr Andrew Jones, has been appointed as a full voting Non-executive Director as of 01.11.14. Professor Richard Kitney will remain being in attendance at the Board with a specific remit if IT as agreed by the Board 25.09.14.

Following departure of Tony Bell, Chief Executive 19.11.14 Elizabeth McManus, Chief Nurse and Director of Quality was appointed as Interim Chief Executive 20.11.14.

Following on the appointment of Elizabeth McManus as Interim Chief Executive 20.11.14 Vanessa Sloane was appointed as Interim Director of Nursing 18.12.14.

Role	Date of change	Full Name	Job Title (if different to 'role')
Non-executive Director	01.11.14	Eliza Hermann	
Non-executive Director	01.11.14	Dr Andrew Jones	
Interim Chief Executive	20.11.14	Elizabeth McManus	
Interim Director of Nursing	18.12.14	Vanessa Sloane	

III. COUNCIL OF GOVERNORS

a. Retirements and Resignations

i. Elected

Status of vacancies filled at election in December 2014.

Category	Constituency	Status at 30 December	First Name	Last Name	Start Date of Office
Patient		Filled	Anna	Hodson-Pressinger	27.12.14
		Filled	Cass J	Cass-Horne	27.12.14

Public	Royal Borough of Kensington and Chelsea Area 2	Filled	Philip	Owen	27.12.14
Staff	Allied Health Professionals, Scientific and Technical	Filled	Diane	Samuels	27.12.14
	Management Class	Filled	George	Vasilopoulos	27.12.14
	Support, Administrative and Clerical	Filled	Lou	De Palo	27.12.14

Constituency	Date of Election	Number of candidates nominated in each constituency	Number of votes cast in each constituency	Number of eligible voters	Turnout (%)
Patient	27/11/14	12	626	6115	10.2
Public: Royal Borough of Kensington and Chelsea Area 2	27/11/14	3	229	1552	14.8
Staff: Allied Health Professionals, Scientific & Technical	27/11/14	1	Uncontested	Uncontested	Uncontested
Staff: Management	27/11/14	1	Uncontested	Uncontested	Uncontested
Staff: Support, Administrative and Clerical	27/11/14	3	103	939	11
OVERALL TURNOUT	27/11/14	20	**958**	**8606**	**11.1**

A vacancy was created in the Staff Constituency Contracted following the resignation of Rochelle Gee 15.10.14.

ii. Stakeholders

There were no changes.

b. Appointments (stakeholder)

There were no changes.

Appendix 3 – Capital Expenditure Declaration

Capital Expenditure Declaration for Chelsea and Westminster

Where year-to-date capital expenditure is less than 85% or greater than 115% of levels in the latest annual plan (or any later capital expenditure reforecast) an NHS foundation trust must submit a capital expenditure reforecast for the remainder of the year. This is set out at the bottom of page 22 of the Risk Assessment Framework issued by Monitor April 2014.

If you have triggered one of these criteria (see worksheet "Capex Reforecast Trigger") then you must complete the worksheet "Capex Reforecast" and sign one and only one of the declarations below. If you have not triggered one of these criteria then please do not input into this worksheet and the worksheet "Capex Reforecast" at all.

Declaration 1

The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the attached reforecast plan.

Signed:

On behalf of the Board of Directors

Acting in Capacity as: [job title here]

Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Declaration Register of Interests Annual Review/4.1/Jan/15
Purpose of paper	This paper provides interests of members of the Board. This is required by the constitution ref section 12.11 and Standing Orders ref section 6. The register is available to the public on request. In addition, Directors are required to state any material interests relating to items on the Board Committee agendas at the beginning of the meeting or when they might become aware of a potential conflict.
Decision/action required/ recommendation	The Board is asked to review and confirm the register as an accurate record. Any changes are to be notified to the Board Governance Manager by end February 2015.
Summary of the key risks/issues from the paper	This paper outlines the external interests of all Executive and Non-executive Directors and other Directors who attend Board meeting.
Link to corporate objectives	None
Non-Executive Sponsor	Sir Tom Hughes-Hallett, Chairman

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors

Draft Register of Interests – January 2015

NAME	INTEREST(S)
Sir Tom Hughes-Hallett Chairman *From 1 February 2014*	Non-Executive Chair of Cause4 Trustee of The King's Fund Trustee of The Sixteen Trustee of The Esmée Fairbairn Foundation Life Vice President of the Michael Palin Centre for Stammering Children Life Vice President of Marie Curie Cancer Care
Sir John Baker Non-executive Director Vice Chair of Board of Directors Chair of Audit Committee Senior Independent Director	Chairman - Bladon Jets Limited; Non-Executive Director - Midway Resources International; Chairman - Motac Holdings Ltd; Chairman - Friends of the Yehudi Menuhin School; Chairman - Cranmer Court (Chelsea) Tenants Limited; Chairman - The Villiers Management Company Limited.
Prof. Richard Kitney Non-executive Director *Until 31 October 2014* *From 1 November 2014 in attendance at the Board with a specific remit if IT as agreed by the Board 25.09.14.*	Director of RIK Consultants Ltd Chairman and Director of Visbion Ltd
Mr Jeremy Loyd Non-executive Director	Non-executive Director of Marine Management Organisation Non-departmental public body DEFRA Non- executive Director of UCL Cancer Research Institute Trust – a charity funding cancer research Blackwells, Book and Information Supplier - Position held Alternate Director
Ms Karin Norman Non-Executive Director Chair of the Assurance Committee	Investment Committee Member, Parkinson's Disease Society of the UK Director Maitland Court Limited

Member of Audit Committee *Until 31 October 2014*	
Eliza Hermann Non-executive Director *Board member from 1 July till 31 October 2014* *Non-executive Director from 1 November 2014*	Positions of authority in a charity or voluntary body: Board Trustee: Marshall Aid Commemoration Commission (2013 – present) Board Trustee: Campaign to Protect Rural England – Hertfordshire Branch (2013 – present) Committee Member, Friends of the Hertfordshire Way (2013 – present) Additional employment: Civil Service Commission, Board Director and Commissioner (1/4/10-31/3/15)
Dr Andrew Jones Non-executive Director *Board member from 1 July till 31 October 2014* *Non-executive Director from 1 November 2014*	Ownership or part-ownership of private companies, businesses or consultancies: AJ Property Management Ltd Additional Employment: Managing Director, Wellbeing Nuffield Health
Jeremy Jensen Non-executive Director *From 1 July 2014*	Directorships held in private companies, Public Limited Companies or Limited Liability Partnerships: MPG Holdings Ltd, Libra Group x 34, Partner Aaronite Partners LLP. Ownership or part-ownership of private companies, businesses or consultancies: Aaronite Partners LLP Connections with a voluntary or other organisation contracting for or commissioning NHS services:HC1 (Part of NHP)
Nilkunj Dodhia Board Member *From 1 July 2014*	No interests to declare.
Liz Shanahan Board member *From 1 July 2014*	No interests to declare.

NAME	INTEREST(S)
Tony Bell OBE Chief Executive Until 19 November 2014	No interests to declare.
Lorraine Bewes Chief Financial Officer	No interests to declare.
Elizabeth McManus *Until 20 November attended as* Chief Nurse and Director of Quality From 20 November attends as Interim Chief Executive	No interests to declare.
Zoë Penn Medical Director	No interests to declare.
Vanesa Sloane Interim Chief Nurse *Attends Board meetings as Interim Director of Nursing from 18 December 2014*	No interests to declare.
Susan Young Chief People Officer and Director of Corporate Affairs *Attends Board meetings as Chief People Officer and Director of Corporate Affairs*	No interests to declare.
Rakesh Patel Director of Finance *Attends Board meetings as Director of Finance*	No interests to declare.

Dominic Conlin Director of Strategy and Integration *Attends Board meetings as Director of Strategy and Integration*	No interests to declare.

Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Safeguarding Children Declaration 2015/4.2/Jan/15
Purpose of paper	CQC and Monitor requires NHS Trusts, FTs, and CCGs to publish a declaration on their websites on an annual basis to confirm they are satisfied appropriate safeguarding arrangements for children are in place.
Decision/action required/ recommendation	For approval.
Summary of the key risks/issues from the paper	The annual declaration confirms that there are appropriate safeguarding arrangements for children at the Trust.
Link to corporate objectives	NA
Executive Sponsor	Vanessa Sloane, Interim Director of Nursing

Safeguarding Children Declaration 2015
As Required by Care Quality Commission and Monitor

Chelsea and Westminster Hospital NHS Foundation Trust is fully committed to ensuring that all patients including children are cared for in a safe, secure and caring environment. As a result a number of safeguarding children arrangements are in place.

These include:

- Chelsea and Westminster Hospital NHS Foundation Trust meets statutory requirements with regard to the carrying out of Disclosure and Barring Service (DBS) checks – all staff employed at the Trust undergo a DBS check prior to employment and those working with children undergo an enhanced level of assessment.

- The Trust has a robust Training Strategy in place with regard to delivering safeguarding training to ensure that staff are trained to the appropriate level required for their role. The Trust reviews its training for safeguarding on an annual basis, including the review of training levels required for different staff groups.

- The Board of Directors receives an annual report on child safeguarding.

- The Trust has an audit plan for safeguarding for 2014/15 which is shared with the Local Safeguarding Children's Board (LSCB).

- The Trust's child safeguarding policies and systems are up-to-date and robust, including a process for following up children who miss outpatient appointments and a system for flagging children about whom there are safeguarding concerns.

- The Trust has named professionals who lead on issues in relation to safeguarding. They are clear about their roles, have sufficient time and receive relevant support and training to undertake their roles, which include close contact with other social care and healthcare organisations.

- The Trust has a named doctor, nurse, midwife and liaison health visitor with responsibilities for safeguarding:

Named Doctor:	Yannis Ioannou
Named Nurse:	Harriet-Ann Thomas
Named Midwife:	Wendy Allen
Named Liaison Health Visitor:	Faye Woods

- The Director of Nursing is the Executive Director lead for safeguarding and chairs the Children's Safeguarding Board, as well as the annual joint Adult & Children's Safeguarding Board.

- The Trust is a member of the Tri-Borough Local Safeguarding Children's Board (LSCB).

Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Business Planning 2015/16 Outline Process/5.2/Jan/15
Purpose of paper	To set out our process for 2015/16 business planning to meet requirements of both our regulators and our own organisation.
Decision/action required/ recommendation	The Board is asked to note the 2015/16 business planning process and approve the proposed process for approval.
Summary of the key risks/issues from the paper	Under national guidance, business planning for 2015/16 is more straightforward than in previous years, requiring a one year operational plan only, within the context of our overarching five year strategic plan. Our approach reflects national guidance, emphasising key messages specific to CWFT. Monitor requires us to submit a high-level draft operational plan for 2015/16 on 27 February 2015 and a detailed plan on 10 April 2015. CWFT has issued detailed business planning guidance to Divisions and the 2015/16 business planning process will form a key part of the Division's quarterly review of business plans on 20 January 2015. The process will be overseen by a Business Planning Steering Group, chaired by Lorraine Bewes and accountable to Corporate Directors and the Finance and Investment Committee. Under the proposed approvals process, the Board will be asked to approve the detailed operational plan for 2015/16 at its meeting on 26 March 2015.
Link to corporate objectives	Achieving clinical and financial sustainability
Executive Sponsor	Lorraine Bewes, Chief Financial Officer

1.0 Introduction

1.1 This paper sets out national requirements and CWFT's approach to business planning for 2015/16.

2.0 Decision/action required

2.1 The Board is asked to note the 2015/16 business planning process and approve the proposed process for its approval.

3.0 Background

3.1 National planning guidance has been published setting out the steps towards implementing the Five Year Forward View (NHS England's overarching strategy published in autumn 2014). Monitor also published supporting business planning guidance for NHS Foundation Trusts in December 2014.

3.2 Under national guidance, business planning for 2015/16 is more straightforward than in previous years. In 2014/15 we were required to submit a five year strategic plan. For 2015/16, the guidance requires a one year operational plan only, within the context of our overarching five year strategic plan.

4.0 Our approach to business planning in 2015/16

4.1 Our approach reflects the national guidance and emphasises two key messages:

4.1.1 CWFT expects to carry an underlying deficit into 2015/16. Therefore, there is no scope to support business planning initiatives and there are no available funds to support developments other than those already identified in financial plans, or in exceptional circumstances.

4.1.2 The FT is looking to use this year of consolidation to re-establish a 'virtuous circle' between quality and productivity improvement and financial performance, as a route to establishing the FT's sustainability.

4.2 The business plan will:

4.2.1 Take account of the FT's existing Strategic Objectives

4.2.2 Highlight key objectives that will be delivered in this year as part of the FT's overarching strategy, including objectives to support quality and productivity improvement and delivery against the CQC action plan

4.2.3 Align with WMUH Integration Plan and prepare for the establishment of a safe, sustainable and clinically effective new organisation, both to enable safe handover (up to day 100) and to enable service standardisation across the combined Trust in quarters two to four 2015/16

4.2.4 Show how we will align resources to deliver these objectives against an established budget.

5.0 Timetable for submission to Monitor

5.1 NHS Foundation Trusts are required to submit a high-level draft operational plan for 2015/16 by midday on 27 February 2015. This will include:

- High level financial projections with underlying assumptions
- A brief narrative explaining key assumptions, drivers of financial performance and the extent of alignment with the FT's main commissioners.

5.2 NHS Foundation trusts are required to submit the final detailed operational plan for 2015/16 by midday on 10 April 2015.

5.3 The detailed timetable is set out in annex 1.

6.0 Launch and oversight of CWFT's business planning

6.1 Detailed business planning guidance for CWFT was sent to Divisions on Thursday 15 January. The 2015/16 business planning process will form a key part of the Division's quarterly review of business plans on 20 January 2015.

6.2 A Business Planning Steering Group has been established to oversee the process. The group is chaired by Lorraine Bewes, Chief Financial Officer, and will account to Corporate Directors and the Finance & Investment Committee. The purpose of this group is to:

- Support Divisions in the delivery of business plans
- 'Hold the ring' on the alignment of plans with corporate objectives, commissioning intentions, 2015/16 contracts (including CQUINs) and emerging priorities in 5 Year Forward View
- Provide clarity and consistency across Divisions including support to the Bilateral Meetings
- Provide specific support through the Acquisition Project Team to ensure consistency with the Integration Plan (including timelines) for the proposed acquisition of West Middlesex Hospital
- Provide assurance to delivery – including the submission of draft and final plans to Monitor.

6.3 Two 'bilateral meetings', between Exec and Division leads for business planning, will be held to provide support and challenge to the draft and final business plans.

7.0 Proposed approvals process

7.1 The proposed approvals process for the operational plan, prior to submission to Monitor, is:

- **Draft operational plan**
  - Submitted to the Finance and Investment Committee for approval at its meeting on 20 February 2015

- **Detailed operational plan**

- Submitted to the Finance and Investment Committee for approval at its meeting on 24 March 2015
- Submitted to Board for approval at its meeting on 26 March 2015

7.2 We will take the draft business plan to the Council of Governors for comment at its meeting on 5 March 2015.

8.0 Summary

8.1 CWFT is undergoing its 2015/16 business planning round, in line with national and trust specific guidance. A Business Planning Steering Group, chaired by Lorraine Bewes, has been established to oversee the process.

8.2 Under the proposed approvals process, the Board will be asked to approve the detailed operational plan for 2015/16 at its meeting on 26 March 2015.

Caroline Windsor
Head of Strategy
19 January 2015

Annex 1: Detailed timetable

Milestone	Responsibility	Time
Expenditure:		
Complete 2014/15 forecast outturn (recurrent & non-recurrent)	Finance & Business managers/ DDOs	16/01/2015
Communicate 2014/15 'rollover' budgets to Divisions	Finance Teams	19/01/2015
Review 2014/15 cost pressures put forward by divisions for inclusion in 2015/16 budgets	DOF & COO	20/01/2015
Implement assumptions listed above for expenditure inflation cost pressures	Finance Teams	30/01/2015
2015/16 new cost pressures put forward to be reviewed and approved by Corporate Directors	Finance & Business managers/ DDOs	30/01/2015
CIP plan drafted	Kingsgate	09/01/2015
Detailed CIP implementation plans presented to Corporate Directors for final approval	Kingsgate/ COO	13/02/2015
Communicate more detailed budgets relating to WMUH to Divisions	Finance Teams	02/03/2015

Income:		
Activity & Income baseline set & tariff impact calculated	Financial Planning Team/ Information	09/01/2015
Communicate 2014/15 'rollover' budgets to Divisions	Finance Teams	19/01/2015
Receive contract offer from CCGs	Assistant DOF	20/01/2015
Propose service developments/ changes in income plan	DDOs/ Divisions	23/1/2015
First assessment of cost of CQUIN and quality, and its impact on contract	Head of Contracts	30/01/2015
Sign off service developments/ changes in income plan	DOF and COO	30/1/2015
High level meeting with commissioners re affordability and any gap	Head of Contracts	06/02/2015
Communicate any material changes to income expected through discussions with commissioners	Finance Teams	06/02/2015
High level agreement with NHSE and CCG on contracts	CFO	20/2/2015
Second assessment of cost of CQUIN and quality, and its impact on contract	Head of Contracts	27/02/2015
NHSE and CCG contracts to be signed off	CFO	09/03/2015
Consolidate contractual agreements to activity and income plan	Financial Planning Team	March 2015
Communicate more detailed budgets relating to WMUH to Divisions	Finance Teams	02/03/2015

Capital:		
Complete 2014/15 forecast outturn capex and associated funding (including carry forward requirements)	Head of Financial Services (and divisional or corporate capital leads)	09/01/2015
Review of 5 year forward capex programme and preparation of proposed changes to reflect business case approvals underway.	Head of Financial Services (and divisional or corporate capital leads)	09/01/2015
Review 2014/15 carry forward requirements requested for inclusion in 2015/16 capex budgets and Review proposed changes to the Capex programme for business cases underway.	DOF & COO	20/01/2015
Divisional equipment replacement and IT upgrade bids submitted by divisions (short description not business case)	Divisional and corporate teams via Finance & Business Managers	30/01/2015
Review of buildings capex programme	Director of Estates, COO and DOF	09/02/2015
Review of IT upgrade bids and feedback to proceed and prepare business cases.	IT Director, COO and DOF	9/2/2015
Review of Equipment replacement bids and feedback to prepare business cases.	Medical Director, Chair of Medical Devices Committee and DOF	09/02/2015
Review and approval of overall capex programme by Corporate Directors	Corporate Directors	13/02/2015
Preparation of business cases for approval for equipment replacement and IT Upgrades.	Divisional and corporate teams via Finance & Business Managers	16/03/2015
Prioritise and approve equipment replacement bids	Medical Director, Divisional Medical Directors and DDOs	31/03/2015
Prioritise and approve IT Upgrade bids	Director of IT, COO and DOF	31/03/2015

Overall Financial and Business Plan:		
High level financial plan produced	ADOF/ Head of Financial Management	6/2/2015
Submit draft operational plan to Head of Strategy / Assistant DOF	DDOs	06/02/2015
First 'bilateral' meeting held with Divisions	DOF, COO, Head of Strategy, DDOs	16/02/2015
Submit high level 2015/16 business plan to FIC	DOF/ CFO	20/02/2015
FIC meeting to consider high level 2015/16 business plan	FIC	26/02/2015
Submit high level 2015/16 business planto Monitor	DOF/ CFO	27/02/2015
Second 'bilateral' meeting held with	DOF, COO, Head of	04/03/2015

Divisions	Strategy, DDOs	
Council of Governors meeting to consider 2015/16 business plan	Council of Governors	05/03/2015
Submit final 2015/16 business plan and PID(s) to Head of Strategy / Assistant DOF	DDOs	09/03/2015
Sign off Divisional financial plans	DDOs/ DMDs	13/03/2015
Submit draft Trust 2015/16 business plan to FIC and Board	DOF/ CFO	18/03/2015
FIC meeting to consider final Trust 2015/16 business and financial plan	FIC	24/03/2015
Board meeting to consider final Trust 2015/16 business and financial plan	Board	26/03/2015
Submit final 2015/16 business plan to Monitor	DOF/ CFO	10/04/2015

Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Quality Committee Minutes – 27 October and 24 November 2014/6.1Jan/15
Purpose of paper	The minutes of the Quality Committee meeting held in October and November 2014 are provided to the Board for information.
Decision/action required/ recommendation	The Board is requested to note the contents of the minutes.
Summary of the key risks/issues from the paper	This paper outlines a record of proceedings of the meeting of the Quality Committee on 27 October and 24 November 2014. Key issues: • Assurance of progress in remediation of issues identified in the CQC report. • Assuring focus and oversight on the key clinical concerns as identified by the Chief Operating Officer, Chief Nurse and Medical Director. Themes include: waiting times for emergency care and waits for elective surgery, timely identification of the deteriorating patient, and the consequences of gaps in managerial and clinical leadership
Link to corporate objectives	Excel in providing high quality clinical services
Executive Sponsor	Eliza Hermann, Chair

Quality Committee, 27 October 2014
Minutes

Present		**Designation:**
Eliza Hermann	EH	Chair
Dr Andrew Jones	AJ	Non – Executive Director
Melvyn Jeremiah	MR	Governor
Elizabeth McManus	EM	Chief Nurse & Director of Nursing
Vivia Richards	VR	Head of Clinical Governance & Risk
Rob Hodgkiss	RH	Acting Chief Operating Officer
Invitee: Holly Ashforth	HA	Acting Deputy Chief Nurse

1. Apologies

Tony Bell, Zoe Penn and Christine Blewett.

2. Introductory remarks

Introduction of whole committee.

Role of NED's

- To provide support to Trust Exec's
- To recognise and focus on constructive challenges

The Quality Committee is a new committee and should not be compared with the previous Assurance Committee.

The committee members will ensure the QC runs accordingly:

- Focused membership
- Focused agenda
- Governance of clinical and patient care
- Open, honest and fully transparent within the team
- Mindful of frequency of meetings
- Focused on how meetings will run
- Concise minutes
- Discussions and actions

Forward planning of agenda items

3. CQC Report

EM confidentially discussed the report which is currently embargoed. HA is currently developing the action plan and will be meeting with teams to take actions forward. Initial plan is for EM to discuss with TB.

Our aim is to:

- engage both internally and externally
- maintain consistency with clear timelines and clear leads

- engage external partners with areas where support is required
- have a clear plan of action

EH confirmed this is an opportunity to engage with staff, listen to their feedback and to give assurance to external bodies that we are capable of the improvements required. VR suggested building on the requested areas of improvement. RH We need to ask staff "how" they prefer their communications without being over complicated. EM: Leadership and management need to have a strong sense of how it engages in the organisation – how do people feel?

Action: Delivery of CQC Action Plan on the agenda every month **DP/ALL**
Action: QC 24/11 to ratify the tabled CQC Action Plan due 28/11/14 **DP/ALL**

4. Top Concerns

Chief Nurse & Director of Quality **DP/ALL**

Highlighted concerns around midwifery and nursing vacancy rate and turnover. Staffing paper in this month's Board papers along with plans for future improvements.

RH: Clinical medical leadership actions need to be owned by the clinical leader. We need to make the roles more attractive to encourage applications (e.g: clinical director posts).

5. DRAFT Terms Reference for the Quality Committee

ToR discussed briefly.

Action: All QC members to send comments to DP within 48hrs of meeting **ALL/DP**
DP send comments to EH by 10th Nov

Action: EM To work with Jo Howard to triangulate the Niche report and send draft to EH by Nov. **EM**

6. Any Other Business

Quality committee to be second Monday of each month at 2.30pm – 4.30pm DP to arrange. **DP**

7. Date, time and venue of next meeting

Monday, 24th November 2014
At 2.30pm – 4.30pm
Verney House Boardroom

Quality Committee, 24 November 2014
Minutes

Present		**Designation:**
Eliza Hermann	EH	Chair
Andrew Jones	AJ	Non-executive Director
Melvyn Jeremiah	MR	Governor
Christine Blewett	CB	Governor
Elizabeth McManus	EM	Chief Nurse & Director of Nursing
Zoe Penn	ZP	Medical Director
Rob Hodgkiss	RH	Acting Chief Operating Officer
Vivia Richards	VR	Head of Clinical Governance & Risk
Holly Ashforth	HA	Acting Deputy Chief Nurse

Preliminaries

EH asked who would be supporting the Committee and taking Minutes as there was no one identified.

Action: ZP to ensure Committee is supported and resourced properly (ongoing) **ZP**

1. Apologies

None.

2. Minutes of the meeting 27th October 2014

Minutes were approved. Remove 'Draft'

3. Matters arising

1. The outstanding actions were all confirmed as being closed at the last meeting.

2. The Terms of Reference were discussed and EH requested that they be edited and checked to ensure that we had appropriate members and had all statutory reporting requirements for this sub-committee of the Board sorted out prior to the next meeting.

Action: ZP to contact Niche Consulting to check the ToR and discuss with EH prior to 12th January 2015 meeting for ratification at this meeting. **ZP**

4. CQC Report and Action Plan

EM set the scene:

- work has been done with divisions and local action plans embedded within divisions to create the full action plan ("the internal document") to respond to the CQC's report
- this action plan needs to go to the CQC in a shorter and more "tick box" CQC-mandated format by 28th November 2014
- EM is going to write a cover letter for the 28th November CQC submission, acknowledging the wider issues noted in the CQC report i.e. leadership and organisation culture

- themes of the report are clear and need to inform the actions going forward.

The Committee then discussed the action plan, including the timeline for delivery, and that accountabilities for completion of each action must be made clear by identifying named individuals. The importance of continuing with the development and launch of the quality strategy was also discussed.

Action: It was agreed that the full action plan (the internal document) be tabled at the next meeting and that this action plan should be a live document with regular updating to reflect progress and to build in accountability. (Holly Ashworth)

Action: For both the CQC-mandated format and the internal document, named individuals are specified for the actions rather than general phrases such as 'lead nurse and clinical leads'. (Holly Ashworth)

Action: The completed CQC-mandated action plan with named leads, along with EM's covering letter, to be sent to Quality Committee members for information soon after submittal to CQC on 28th November

Action: Executive and ZP to continue the development and operationalization of the Quality Strategy.

5. Top Concerns

Chief Operating Officer . RH said he had two broad concerns:

- A&E 4 hour ED waits are difficult to achieve.
  RTT backlog: outpatients reducing backlog and now compliant. Admitted patients: still 302 patients adrift of sustainable position ongoing. The Trust has made a lot of progress so far and much quicker than most organisations so relatively it is doing well but the Trust will not be compliant.

Concerns about current management bandwidth. Too stretched and cannot afford to lose anyone else

Medical Director:

- Compliance with NEWS scoring – this has improved but SUI's still coming through. Have been shortlisted for national tech fund to support bedside recording of vital signs and appropriate and early action on sepsis.
- Medical Leadership
  Clinical directors and a Divisional Medical Director are still missing and the lead for the Sepsis project already runs AAU. There is a difficulty in finding people with appetite, competence and confidence to take on the roles.

EM and ZP confirmed a talent review is underway and there is a tender out for a leadership development programme for clinical and non clinical staff.

Chief Nurse and Director of Quality

EM said she had the same concerns as RH and ZP

- gaps in leadership and management throughout the organisation in terms of medicinal management and nursing leadership

Action: EH said it would be helpful for EM to speak to the Chairman before the Board meeting later that week as the issues of clinical and nursing leadership gaps and nurse staffing levels have been identified as a priority at two

committees and help is required from the Board to make headway. EH suggested Susan Young, Chief People Officer, takes this forward

6. Draft Terms of Reference for the Quality Committee

Action: EH interested in seeing the ToR for the Quality Committee prior to next meeting. ZP to contact Jo Howard from Niche consulting to ensure robust terms of reference for sign off at next meeting in January.

7. AOB

- EH asked for information about the Clinical Summit taking place on 3 December.

  ZP said the summit will address what is important to the Trust.
  - The Chief Executive of the Royal College of Physicians will talk about the shape of the future hospital, looking at the clinical themes over next 20 years and the direction hospitals will take.
  - The position regarding WMUH (30 colleagues from West Middlesex are attending)
  - Quality strategy
  - Gary Davies re NEWs and sepsis project

Action: ZP to send CB the agenda.

- January meeting

Action: ZP and VR to check the timetable to ensure the Agenda includes any overdue items such as statutory reports

Board of Directors Meeting, 29 January 2015 PUBLIC

Subject/Title	Register of Seals Report Q3/6.3/Jan/15
Purpose of paper	To keep the Board informed of the Register of Seals.
Decision/action required/ recommendation	The Board is asked to note the report.
Summary of the key risks/issues from the paper	There were no documents to which the seal was affixed during the period under review.
Link to corporate objectives	NA
Executive Sponsor	Susan Young, Chief People Officer and Director of Corporate Affairs

Register of Seals Report Q3

Section 12 of the Standing Orders provided below refers to the sealing of documents.

12.2 Sealing of documents

12.2.1 Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief
Executive, and not also from the originating department, and shall be attested by them.

12.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an employee nominated by him/her) and authorised and countersigned by the Chief Executive (or an employee nominated by him/her who shall not be within the originating directorate).

During the period 1 October 2014 – 31 December 2014, there were no documents to which the seal was affixed.